MASTER' THESIS
FINAL DISSERTATION

Humanisation of Childbirth in German Hospitals:
A Peace Perspective on
Dehumanised Childbirth and a Proposal to Transform it

International Master in Peace, Conflict and Development Studies

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Abstract

This thesis argues that a peaceful transformation towards humanised childbirth in German hospitals is necessary to minimise the impacts of dehumanised structures in form of direct, structural and cultural violence in childbirth. Dehumanised childbirth is ignoring women's right of a respectful und humanised maternity care. Humanised childbirth contributes to strengthen the relationship between mother and healthcare provider, family and her child. By transforming dehumanisation through using peace concepts and tools such as imperfect peace, cultural of peace, ethics of care, conflict transformation and moral imagination, provention, Nonviolent Communication and Peace Circle, the cultural change towards humanised childbirth in Germany can be supported.

Esta tesis sostiene que una transformación pacífica hacia el parto humanizado en los hospitales alemanes es necesaria para minimizar los impactos de las estructuras deshumanizadas en forma de violencia directa, estructural y cultural en el parto. El parto deshumanizado es ignorar el derecho de la mujer a una atención materna respetuosa y humanizada. El parto humanizado contribuye a fortalecer la relación entre la madre y el proveedor de atención médica, la familia y su hijo. Al transformar la deshumanización mediante el uso de conceptos y herramientas de paz como la paz imperfecta, la cultura de la paz, la ética del cuidado, la transformación del conflicto y la imaginación moral, la provisión, la comunicación no violenta y el círculo de la paz, se puede apoyar el cambio cultural hacia el parto humanizado en Alemania.

Keywords: Humanisation and Dehumanisation of Childbirth, Obstetric Violence, Medicalisation, Transformation, Peace, Conflict, Germany

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The birth is a wonder - Mirum partu.

If we hope to create a non-violent world where respect and kindness replace fear and hatred, we must begin with how we treat each other at the beginning of life. For that is where our deepest patterns are set. From these roots grow fear and alienation,

— or love and trust.

Suzanne Arms – A Handful of Hope (poem)

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List of Abbreviations

C-section	Caesarean section
CDMR	Caesarean Delivery on Maternal Request
CRC	Convention of the Rights of the Child
CTG	Cardiotocograph
DGGG	Deutsche Gesellschaft für Gynäkologie und Geburtshilfe (German Association for Gynaecology and Obstetrics)
DRG	Diagnosis-Related Group
FIGO	International Federation of Gynecology and Obstetrics
ICI	International Childbirth Initiative
ICM	the International Confederation of Midwives
IMBCI	International MotherBaby Childbirth Initiative
IMBCO	International MotherBaby Childbrith Organization
IPA	the International Pediatrics Association
IQTIG	Institut für Qualitätssicherung und Transparent im Gesundheitswesen (Institute for Quality Assurance and Transparency in the Healthcare Sector)
NVC	Nonviolent Communication
PTSD	Post-Traumatic Stress Disorder
RAD	Reactive attachment disorder
SDG	Sustainable Development Goals
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation
WRA	White Ribbon Alliance

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1. Introduction

"Death, like birth, is a secret of Nature" (Marcus Aurelius)

1.1. Starting with my own story

During summer 1995, I was reading my two favourite books over and over again. The first one, 'A Child is Born' by Lennart Nilsson, was showing coloured photographs of embryos and foetuses inside the womb, beginning with conception and ending with birth. I was fascinated by these pictures depicting the different stages of a foetus. With the help of these photographs, I could imagine how my little brother, growing in my mother's womb looked like. In the second book, titled 'Our New Baby' by Grethe Fagerström and Gunilla Hansson, a father explained to his son and daughter the development of a baby, from the process of conception to birth. This children's book answered my questions regarding how a baby develops and which role the mother and the father play in this process. I was prepared for my little brother whom I welcomed in September 1995 and carried around like my doll. A few years later I arrived at the conclusion that my dream was to become a midwife. The miracle of birth and how a baby develops as well as growths inside the womb continued to fascinate me until today.

At age 28 I found myself working as an intern in a delivery room of a German hospital as well as with a freelancing midwife. I chose this internship with the intention of discovering whether my previously created image of midwifery was still my reality and if I still wanted to become a midwife. I am a Geographer, an Economist, a Development critic and a Peacemaker who is still fascinated by the miracle of birth, thus I worked for three weeks in a delivery room as part of a team of midwives and accompanied a midwife during her home visits to mothers in the postpartum period for an additional three weeks. I witnessed five natural births and one Caesarean section (C-

section); I was holding hands, supporting and feeling the tension of this moment. I was overwhelmed by a power which filled the delivery room and originated from the women giving birth and their midwives.

This power contained sparks of fear, trust and hope. I needed to have trust in the words and actions of the midwives, even though I felt the fear and the hope of the mothers. With no medical background, I could not assess the seriousness of the situation. One midwife told me afterwards: "that, what you have seen in the hospital is not normal". I started to understand her statement after weeks of listening to women, their experiences and reading about violence during childbirth. Women, midwives, psychologists, physicians and the media have recently started to talk about violence during childbirth in German hospitals.

From my mother who is a physiotherapist and a specialist for traumatised newborn, I knew that birth can have a high impact on the child and its mother. In my family, it is not a secret that my mother and my older brother have suffered from traumatic birth experiences. Although I knew that birth could have such an impact, I did not imagine this extent of violence during childbirth (obstetric violence) in German hospitals.

Now, another year later, I have an overview of the state of research on dehumanised childbirth, have talked to mothers, midwifes and psychologists about their experiences. I have learned, that this phenomenon is tabooed within the German society and its impacts are underestimated even though it occurs worldwide. I am also preparing myself for my first childbirth experience in few months.

1.2. Personal Motivation

My personal motivation is to understand the complex dehumanised structures within childbirth in German hospitals and the impacts these structures can have on

mothers, parents, children and healthcare provider as well as their relationship. My sense for equity and justice which guides my inner conviction about life, motivated me to conduct this research. The present study helps me to better understand the personal question why birth, the first crucial point of every life, is not seen and respected in its importance for a healthy society. My definition of life starts before birth, and I perceive the moment of birth as a step into the secularity in which a human becomes visible. However, the time before and during birth is as important as the one after birth, and the impacts of this time can be life-changing.

I would like to contribute to a positive change within society towards a humanised childbirth and a respectful view towards life in the prenatal, natal and postnatal periods.

This research is the first step on this journey, focusing on the time period during birth and the existing dehumanised structures. My work contributes to a positive and peaceful change and encourages a transformation of the occurring violence. Thereby childbirth is perceived as an interdisciplinary phenomenon which has a long-life impact on the child and its relationships.

My internship took me back to the field which I once dreamed of working in. I am now looking at this phenomenon from a social and political science perspective and with a background in geography, economics and development studies. The peace perspective complements this view and is supported by a Master's degree of International Peace, Conflict and Development.

With a focus on the various relationships between and within different entities – medical staff, mother, life partner, child, family and society – the importance of community becomes visible. The impacts of dehumanised childbirth on the various relationships cannot be underestimated. These relationships create a web in which a healing process of a traumatic birth can be processed. The peace perspective is supporting

this holistic view on relationships and its importance to transform the impacts of violence. It further offers various ways to change perspectives and helps to not insist on victimisation, conviction or simplification.

The reason why this research is not only focussing on the impact on one actor, for example the mother, is due to the complexity of the web of different individuals since the experience of violence is never just impacting one person.

1.3. Contextualised Research

The discussion on dehumanised childbirth, medicalisation and especially obstetric violence is guided by international organisations. Various studies and articles discuss violence in maternity care in developing / low-income countries or focus on extreme C-section rates. The WHO defines violence in maternity care as actions and processes that have a negative impact on the health of the child during pregnancy, childbirth or the puerperium and influencing, altering or damaging the relationship between women and their children (WHO 2015b, 1). Questions about the receiver of violence, the individual who is experiencing the actions as a form of violence and how violence is defined are arising in the context of obstetric violence and dehumanised childbirth research. Violence exists and has to be discussed, however, the individual perception of all actors has to be recognised.

Obstetric violence can be seen within diverse power structures which are influenced by different actors and genders. This violence can be performed or tolerated by one individual, a group or the government. Within a childbirth all three levels are existing (Mundlos 2015, 32). Physical and sexual violence include every form of mistreatment and injuries. The difficulty for affected women is the differentiation of medical necessary and unnecessary injuries (Mundlos 2015, 33). Women have shared

their experience about unnecessary genital examinations, Kristeller manoeuvre, opening from Amniotic Sac, unnecessary episiotomy, forced delivery of placenta, limited or forbidden mobility and other unnecessary medical intervention as forms of physical violence (Neumann and Maier 2019, 112). Sexual violence does not mean libidinal motivated acts, but rather provides a space of aggression and abuse of power (Mundlos 2015). Besides physical violence there is psychological violence. This kind of violence is difficult to define and ranges widely, but the ignorance of needs, insults, threats, defamations, devaluation and fear is a form of it (Mundlos 2015, 35).

Obstetric violence includes more than direct violence. Especially in countries with a high medical standard, the effects of medicalisation and technologised labour as well as structural violence are influencing childbirth and the relationship between mother and child. Germany is one of these countries with high-tech medicine on the one hand and an invisible obstetric violence on the other hand. In the German society, obstetric violence during childbirth is not widespread and only discussed in specific circles, which is why women are not recognising their experience as violence which keeps this circle of violence alive.

Programs and action plans focussing on respectful maternity care, the rights of women and minimisation of violence (direct, structural and cultural) are mostly implemented through international organisations like the United Nations and the World Health Organisation (WHO) or national governments. Since 1985 the WHO has been concerned about the excessive medicalisation of birth and its linked violent procedures, which is why the organisation has promoted respect and autonomy during childbirth through different campaigns (Sadler et al. 2016, 47). However, only in 2014, when the call for greater action became louder, the WHO tried to close the gap between the mistreatment during childbirth and the violation of (women's) human rights by

formulating guidelines of a respectful maternity right (Khosla and Zampas 2016, 131). This right states that, "[e]very woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful healthcare throughout pregnancy and childbirth, as well as the right to be free from violence" which includes gender violence (WHO 2015b, 1). Furthermore, a publication on the iatrogenic harm of obstetric intervention and its impacts for mother and child diminishes the topic's taboo status (Zeitlin and Mohangoo 2008, 63).

Besides the discussion of dehumanisation of childbirth there is another about humanisation of childbirth, which does not focus on violence or the action against it, but rather on the importance and the impact of qualitative humanised care. Human-centred care which promotes dignity, respect and the relationship between the care giver and receiver functions as a balance towards dehumanised structures. Especially, the focus on humanised childbirth increased due to the effects of harming structures which support or create various forms of violence impacting mothers, children, life partners and medical staff. Research has shown, that a positive support is having a great influence on pregnancy and childbirth outcomes. The goal is to experience childbirth as a positive procedure focusing on the woman giving birth, having control of herself and her body.

The actions against dehumanisation and the promotion of humanisation of childbirth are working towards the same direction. The goal is to reach a humanised childbirth in which medical processes are complementing humanised behaviour and views of care through evidence-based practises. This study promotes, that both approaches interact instead of outweighing each other. Within this interaction both programs focusing on structural deficits and programs, promoting qualitative care are working together. The respect and consideration of different perspectives allows the inclusion of a variety of approaches. "The most practical way to perceive the need for

humani[s]ation of health is to observe the consequences of its absence" (Marques et al. 2020, 8).

The consequences of dehumanised structures in childbirth in Germany are visible. In 2010 over 30% of all childbirths were C-sections (Kolip, Nolting and Zich 2012, 6) and only 6% occur without any medical interventions (Mundlos 2015,39). In a European comparison Germany occupies a place at the lower end of humanised childbirth.

This thesis states, that the impact of dehumanised structures in childbirth in German hospitals on the mothers, the children, life partners, the medical staff and society have to be understood as an interdisciplinary phenomenon. This phenomenon occurs within medical science as well as peace and conflict studies and engages with mothers, midwives, obstetrician, psychologists and activists. Its interdisciplinary perspective contributes to the discussion mentioned above, thus providing a more holistic picture of obstetric violence, dehumanised and humanised childbirth. Based on this knowledge, the present study aims to explain the complexity of the structures in dehumanised childbirth by including different perspectives of various actors, to analyse the existing actions and combine them with peace-making ideas to promote humanised childbirth.

While violence during childbirth is a worldwide phenomenon, focus will be laid upon on German hospitals to understand the linkage between medical care and the incomprehension of the importance and long-life impacts of a humanised birth.

As this thesis is taking an interdisciplinary approach, it is as well directed to a wide range of actors; scholars from the medical, social and political science, midwifery, peace and conflict studies, (pregnant) women and (expectant) parents.

1.4. Research Questions and Objectives

The present study is based on the problem of dehumanised childbirth and obstetric violence in form of direct, structural and cultural violence. The latter is faced during delivery and infringes women's rights of respectful and humanised maternity care as well as affects their relationship to their child, partner and health care provider. A peaceful transformation towards a humanised childbirth is necessary to protect the MotherBaby-Family unit and promote a cultural change within the German birth culture.

This research is based on the following four questions:

1. Which conceptual ideas create humanised childbirth?

2. What are the dehumanised structures creating obstetric violence within childbirth in German hospitals?

3. How are the dehumanised structures affecting the relationship between medical staff, mothers, the children and families?

4. How can an interdisciplinary transformation, guided by concepts of different actors and peace studies, towards a humanised childbirth in Germany look like?

The objectives of this study are as follows:

1. Analyse the conceptual ideas of humanised childbirth.

2. Identify, the dehumanised structures of childbirth in German hospitals, creating obstetric violence, according to the three types of violence by Galtung.

3. Highlight the impacts of dehumanised structures in childbirth on the relationship between medical staff, mothers, the children and families.

4. Explore the different perceptions of humanisation of childbirth of different actors and combine them with peace concepts as well as tools to create an

interdisciplinary proposal to transform dehumanised structures towards a humanised childbirth in Germany.

1.5. Literature Review

In terms of literature, mainly secondary sources like journal articles, research analysis, textbooks, political writings, newspapers and websites of organisations were assessed. The three main chapters – Humanisation, Dehumanisation on Childbirth and Peaceful Proposal towards a Humanised Childbirth – differ in their approach, perspective and literature, however, no single literature or scholar leads the discussion.

The issue of humanisation of healthcare will be discussed in this subchapter guided by the philosophical approach of Todres et al. (2009) and the systematic review by Busch et al. (2019) which focus on elements and barriers of humanisation. This combination creates a broad theoretical foundation for the focal point of humanisation of childbirth. The philosophical concept by Todres et al. provides the base of further concepts, including a more specific one about various actors and their individual needs. This broad understanding is complemented by Umenai et al.'s (2001) definition of humanisation of childbirth.

The discussion on humanisation of childbirth is dominated by four groups of scholars. All of them have their own emphasis regarding humanisation of childbirth. Curtin et al. (2020) highlight, that humanised care has a positive impact on pregnancy and childbirth which is why the behaviour and the clinical attributes need to be clarified. Women and healthcare providers are benefiting from humanised care. Curtin et al. (2020) argue that humanisation does not represent the opposite of medicalised care, but highlights that medical interventions need to be evidence-based. Wagner (2001) and Possati et al. (2017) agree to this argument and add that the human, the woman giving

birth, should be at the centre of care. This care has to be adapted to the needs of the woman and she should have control over her own birth. Wagner (2001) further supports the idea, that a combination of the advantages of Western medicine and humanised care is necessary and has to support a cultural change. The last group of authors Behruzi et al. (2013) view humanisation on childbirth from a cultural perspective and define birth as a cultural and social event which needs a cultural support system. This cultural aspect is often neglected by the analysis of (de-) humanised childbirth but provides a crucial aspect for this research.

The issue of dehumanisation of childbirth is discussed in various subchapters, starting with the background knowledge about dehumanised childbirth, its development, elements and characteristics (Haque and Waytz 2012; Haslam 2006). Further the role of medicalisation, its boom and bane character as well as its development (Jardim and Modena 2018; Kukura 2018) are discussed. The chapter continuous with a comprehensive discussion on obstetric violence. Medicalisation has changed the perspective of childbirth within the last centuries and has influenced the social understanding of women, birth, gender and medicine (Johanson 2002; Jung 2017). In this context Jung (2017) and Jardim and Modena (2018) take a feminist view and critically discuss the influence of patriarchal authorities. Obstetric violence can be discussed from various angles, thus the concept of violence (Galtung 2013a; Imbusch 2003; Rauchfleisch 1992) and the terminology of obstetric violence need to be clarified. Hildebrandt (2012) provides an interesting input to this conceptual discussion with his social and cultural view on childbirth. Kukura (2018), Sadler et al. (2016), Savage and Castro (2017), and Sen et al. (2018) further address the question of terminology and origin of the concept of obstetric violence within the international context. They highlight its advantages and disadvantages as well as limitations and opportunities in comparison with other approaches. A comparison of three

included studies shows these differences regarding perceived opportunities and limitations within the concept and research (Freedman et al. 2014, Bohren et al. 2015, and Bowser and Hill 2010). Further this chapter provides the theoretical explanation on obstetric violence and the division of its characteristics into the three forms of violence – direct, structural and cultural – according to Galtung. Mundlos (2015) and Brock (2018) are adding relevant knowledge through the inclusion of a focus on the German context. In addition, quantitative statistics on direct violence, physical abuses, C-sections and episiotomy in Germany are provided by studies and guidelines of DGGG (2020), IQTIG (2017) and Kolip, Nolting and Zich (2012). Based on the research of Thomas et al. (2000), Clesse et al. (2019), WHO (2015), WHO (2020) and Zahn et al. (2006) Germany can be ranked and compared within the international context. A long list of scholars guide the discussion of the various characteristics of obstetric violence like the Kristeller manoeuvre (Diniz and d'Oliveir 1998, Habek, Bobić and Hrgović 2008, Kainer 2016 and Kemper 2014) or the birth position (Bodner-Adler et al. 2001, Thies-Lagergren et al. 2013, Mselle and Eustace 2020 and Reid and Harris 1988,). Kukura (2018) and Mundlos (2015) explain how structural violence is part of obstetric violence in Germany. The third type of violence, cultural violence within obstetric violence, is discussed by various scholars Ahorner and Schadauer (2008), Brock (2018), Douse (2004), Kizilhan (2016), Sadler et al. (2016) and Schmiedebach (2002). Thereby socialisation, the working conditions, the perspective of society and the cultural understanding of pain play a decisive role.

Subchapters 3.3. and 3.4. are based on the previously generated knowledge and complement this knowledge with a perspective on gender and legal considerations. The patriarchal structures which influence the values of the medical system, the patriarchal and feminist discourse, the control over the female body and the male-oriented medicine

are a few aspects which are discussed by Diniz and d'Oliveir (1998), Lee and Kirkman (2008), Sadler et al. (2016) and Shabot (2015). The combination of various perspectives within obstetric violence as well as international and national rights require further discussion. The latter is based on publications by BMFSFJ (2014), Khosla and Zampas (2016), UNHCHR (1989), UNICEF (2014) WHO (2014) and Zimmermann (2017).

The final subchapter (3.5.) addresses the impact of obstetric violence on different actors and is thus of crucial importance for this study. After the analysis of different impacts on different actors, various scholars are included into the discussion. A focus is thereby laid upon psychological effects like PTSD, sleep disturbance (Weidner et al. 2018), re-traumatisation, shame or panic attacks due to obstetric violence since they are long-lasting. In addition, physical impacts are discussed and classified. In general, this research analyses the impacts of obstetric violence on women, children, life partners and medical staff (Albrecht-Engel 2018; Ayers et al. 2006; Brock 2018; Mundlos 2015; Renz-Polster 2018; Simpson and Catling 2016; Thurmann 2018).

The fourth theoretical chapter contains the proposal, which includes an analysis of different actions, guidelines and recommendations of international and national actors.

Initially, general elements of the transformation towards a humanised childbirth, which is aligned with the aspects of humanisation, will be analysed. This discussion will be guided by many scholars which have been mentioned throughout the previous chapters (Haque and Waytz 2012; Jardim and Modena 2018; Marques et al. 2020; Possati et al. 2017; Sadler et al. 2016; Vogel et al. 2015; Wagner 2001).

The second part of the proposal then presents, discusses and analyses the recommendations of the UN (2019) as well as health objectives and studies of the German government (Altgeld and Kuhn 2017; BMG 2019), the request of the green party of the German government (Bündnis 90/Die Grünen 2020), the international guideline of the

International Childbirth Initiative (Lalonde and Pascali-Bonaro 2018), the program of respectful maternity care of White Ribbon Alliance (WRA 2020) and the national ideas of Mother Hood e.V. (2020).

Thirdly different actors – medical staff, pregnant women and research – who take an active role within the transformation will be assessed. The mentioned recommendations are provided by various scholars whose input has guided the discussion on humanised childbirth.

The last part of this chapter discusses the views of the peace scholars into the discussion, adding the final required piece of theoretical knowledge to create a peaceful transformation towards humanised childbirth. The concepts of imperfect peace (Muñoz 2010), culture of peace (Reardon 2001), ethics of care (Comins Mingol 2009, MacLellan 2014; Newnham and Kirkham 2019), conflict transformation (Lederach 2003), concept of *provention* (Cascón Soriano 2001), Peace Circle (Pranis 2005) and Nonviolent Communication (Rosenberg 2015) will guide the formation of the final proposal in the last chapter.

1.6. Research Methodology and Limitation

The research methodology of this study is characterised by the multi-faceted and diverse elements of the mosaic of peace studies. In my view peace studies are an open, not limiting but rather inspiring and inclusive mosaic of many pieces. Each of these pieces can be seen in their individuality, combined in new connections or understood as a moving and changing whole. To me peace studies describe an understanding of seeing the world through a specific lens, which makes it possible to establish new conjunctions. Therefore, new ideas can be generated through the inter-, multi- and cross-dimensional character of peace studies.

This research is a good example of these newly created conjunctions, because it combines different concepts and understandings and considers them through the lens of peace studies. By looking at different views of humanisation and dehumanisation of childbirth in German hospitals various concepts of health, care, feminism, gender, rights, philosophy, violence, peace and transformation are connected. Thus, the methodological discourse of this thesis is not guided by one concept or theory. However, my understanding of peace provides a roadmap for this journey, which helps to explore different parties, goals and issues; to create open spaces; to include complexity, creativity and nonviolence; to focus on invisible effects of violence; to give voice, understanding and empathy to all parties and to focus on peace-making. Through this lens new connections within the web can be recognised and strengthened.

My theoretical understanding of peace was shaped through this Master's degree of International Peace, Conflict and Development. Various scholars, some of them touched me personally, changed my view of the world and are the pillar of my understanding of peace. I would like to mention John Paul Lederach, Marshal Rosenberg, Franciso Muñoz, Paco Cascón Soriano, Paulo Freire, Vandana Shiva, Johan Galtung and Martínes Guzmán in this context. While not all of them are directly included in this research, they represent my personal perspective which influences and shapes my knowledge, skill and experiences.

In addition to the theoretical understanding of peace studies, subjective research resources exist which have shaped and influenced my view. I am a young German woman of childbearing age, who is interested in medical science, psychology, maternity as well as childbirth. I have a strong sense of equality, justice and perceive healthy interpersonal relationships as the basis for a peaceful society. This means, that the different included concepts, the selected scholars, the personal understanding of peace and my individual

perspective which is shaped by my cultural, theoretical and practical experiences create a new web of knowledge.

By choosing peace studies as the lens of this research, the goal is to use its diversity and to think differently about the current situation by creating new connections, ideas and perspectives through the use of creativity and imagination.

This study follows a qualitative approach, investigating different actors and perspectives of humanisation and dehumanisation of childbirth in German hospitals. The considered actors include medical staff (midwives and obstetricians), (pregnant) women, children and life partners who are directly involved in the birth procedure. Secondly, politicians, activists, scientists, legal scholars and the German society who are playing an important background role are considered. This duality emphasises that the units of analysis are dynamic rather than constant and reach from individuals, groups, gender, and states to national and international organisations.

This research was carried out in a theoretical and scientific way with a hermeneutic research approach, however my personal relation to the context, my ability and interest to see and protect vulnerable people in a group/context directed its ethics. The knowledge which constitutes the research questions is mainly based on discourses, research papers and scientific studies. My personal experience in the delivery room is not included into this research, but the professional and personal experience of the internship in combination with my individual position as a woman have influenced my knowledge and understanding of the topic and may have biased my perspective.

After my internship in the delivery room I got interested in obstetric violence and started to read different testimonies of women, midwives, obstetricians and life partners about their experiences as well as articles and scientific studies. This study is based on secondary sources selected according to their lens, focus and authors. I intended to include

various perspectives from different actors and cultural settings to gain a better understand about Germany's position and ranking regarding the phenomenon of obstetric violence. I quickly realised that a one-sided approach to this field is not possible and reasonable. The web of actors is characterised by complexity and interconnectivity which made this research a long and interesting investigation. By giving various actors a voice, considering several perspectives and including different approaches this web became clearer. I was convinced that this research would require a context, different approaches, specific actors and an analysis of their interactions. My focus was laid upon the relationship between mother, child, family and medical staff throughout this investigation. Furthermore, I decided to focus on Germany as a case study with qualitative and quantitative data which exemplify dehumanised childbirth. I chose Germany because I wanted to analysis and question my own cultural setting. Secondly, my prior experience from a German hospital which I wanted to support with a theoretical and scientific background guided this decision. Lastly, my personal shock about the dimensions of obstetric violence in Germany motivated this research. The in-depth and critical analysis of obstetric violence in Germany provided in the third chapter of this study was important to understand the web and its interconnections, but inadequate to follow a proactive peace approach. My approach was guided by the question where peace(s) lied and where to begin the transformation of obstetric violence. The second part of the research allowed the inclusion of the second group of actors involved in and essential for the proposed transformation. Through the analysis of different ideas, requests, programs and guidelines of national as well as international actors, existing gaps were identified. The lens of peace studies highlighted the lack of peace elements in this complex phenomenon which lead to the development of an individual proposal in chapter four. This process was guided my intention to include myself with my own capacities as a peace maker into this setting. My

understanding of peace and peace education helped me to unite my personal capacities in Nonviolent Communication and Peace Circle into this complex phenomenon. In the end this research became more than just a theoretical analysis of obstetric violence in German hospitals, it became my personal affair to be a part of the change towards humanised childbirth in Germany.

The limitations of this research are based on the generalisation of the dehumanised structures and all birthing women in German hospitals. The medical conditions/history, medical emergencies and lifestyles (general health, diet and sport) which influence pregnancy, birth and postpartum period were excluded. Furthermore, the cultural and social economic diversity within Germany was excluded. The list of limitations will be to be complemented and reflected upon at the end of this research (see chapter 5.2).

1.7. Outline of the Paper

This study is structured into three thematic chapters. The first chapter is shorter than the following ones since a detailed picture of a utopian situation of humanised childbirth, an unattainable goal, will not be provided. It was rather aimed to create an understanding of a concept of humanised childbirth illustrating the impacts of dehumanisation of childbirth and obstetric violence in German hospitals. The study concludes with a proposal which combines the complex understanding of these structures, the present ideas of different actors as well as peace concepts and tools.

The first chapter provides an introduction of humanisation of healthcare with a focus on humanisation of childbirth. However, not all possible elements of humanised childbirth are mentioned to allow space for possible interpretation and implementation in different contexts. The aim of this chapter is to develop a general framework in which humanised childbirth can be created. This general framework was created since the

different cultural understandings of childbirth, humanisation and dehumanisation are characterised by diversity. Secondly, possible transformations may be diverse hence requiring guidance rather than a fixed concept. Upon introduction of a philosophical understanding of humanised healthcare, the continuum of different dimensions of humanisation and dehumanisation will be discussed and deepened. The second part will focus on humanised childbirth which puts these dimensions into a specific context and creates the main understanding towards the transformation proposal this study aims to create.

The second chapter starts with the introduction of dehumanisation of childbirth and the development of medicalisation of childbirth. Further, the major part of this chapter addresses the complexity of obstetric violence. Initially, an analysis of violence through the lens of peace perspectives and the three types of violence by Galtung (2013a), will be performed. Also, obstetric violence within childbirth in German hospitals will be explained in detail based on the three types of violence – direct, structural and cultural – according to Galtung. Each type will be explained and underpinned with examples. A special focus will be laid upon three examples of direct violence – physical abuses, Caesarean section and episiotomy – which will be analysed in detail and supported by statistical data. The second half of this chapter will combine obstetric violence with gender as well as international and national rights. This chapter closes with an extensive declaration of the impacts of obstetric violence in order to create the link between the relationships within the web of multiple actors.

Based on the understanding of humanisation and the complex phenomenon of dehumanised childbirth in German hospitals, the third chapter aims to present different actors within this field, their ideas of transformation, various peace concepts as well as tools and will finally combine them within a proposal of transformation towards

humanised childbirth. The proposal is the heart of this chapter, or even of this research, because it represents my personal view and possibility of putting my capacities into practice. The choice of the peace concepts is based on my personal understanding of peace, conflict and conflict transformation. Furthermore, the chosen tools align with my personal capacities to create peace, transform this structure and contribute to this transformation in the future. This research concludes with a summary of the main findings, a presentation of the existing limitations as well as gaps and recommendations for further research.

2. Humanisation

This thesis is considering humanisation and dehumanisation as a continuum with different elements which can be seen as opposites in their extreme versions or as parts on a linear scale with different degrees. The context and time has to be respected to evaluate which elements are relevant for which setting.

This chapter is starting with a general understanding of humanisation of healthcare and including concepts and elements, which support and prevent the process of humanisation. The philosophical understanding of humanisation of Todres et al. (2009) forms the basis for further concepts like the one of Busch et al. (2019) which will also be discussed.

The second part of this chapter focus on the process of humanisation of childbirth and puts the more general understanding of care into a precise content of childbirth.

This overall goal of this chapter is to draw a rough picture of humanisation of childbirth to set the general frame of this thesis. Precise elements of humanised childbirth will not be presented in this chapter to not exclude possible ideas of transformation.

2.1. Humanisation of Healthcare

Along the development of technological advances, a growing specialisation and enhanced research health and well-being have been improved. However, the human dimension of care has been "obscured by a sometimes-necessary technological and specialized focus" (Todres et al. 2009, 68). It is even seen as a failure of the medical science to glorify the reductionism and to overlook the human dimensions of health and illness. For the described development, the value base of being human was not used. The main constituents of what it means to be human has to be considered and formulated to evaluate the (de)humanisation of care. Todres et al. (2009) are describing eight philosophical dimensions of humanisation of healthcare and defining these dimensions as a continuum which goes from the supportive and positive elements through to the barriers of humanisation. It is not a dualism. Between the bipolar terms of humanisation and dehumanisation is a spectrum of possibilities with influencing elements, which need to be considered in their (cultural) context. The framework with its value base, which is determined out of these eight philosophical dimensions, has the potential to describe humanising and dehumanising elements within healthcare. The eight dimensions are: insiderness – objectification, agency – passivity, uniqueness – homogenization, togetherness – isolation, sense-making – loss of meaning, personal journey – loss of personal journey, sense of place – dislocation and embodiment - reductionist body. (Todres et al. 2009, 68-70). They can be overlapping within and between other concepts of humanisation and dehumanisation, for example, Haque and Waytz (2012) are formulating in their article six causes of dehumanisation and propose suitable indicators. These six causes will be used for the discussion of dehumanisation in childbirth in the third chapter. However, the philosophical dimensions, especially the barriers of

humanisation, of Todres et al. (2009) can be seen as the underlying dimensions of the six causes of dehumanisation of Haque and Waytz (2012).

The description of the eight dimensions of Todres et al. (2009) will start with insiderness, which expresses what makes us human. It is a "view of living life from the inside" (Todres et al. 2009, 70) to carry and know the individual sense. The "sense of feeling, mood and emotion is the lens by which our worlds are coloured" and it helps to evaluate values. On the opposite side of insiderness stands objectification, which describes the approach of turning people into objects and focussing on how the object fits into a system.

The second dimension is 'agency' and focuses on the capability of a human to make and be accountable for its own choices and action. This dimension is closely linked to dignity. The 'agency' can be increased by promoting participation of the person. Whereas passivity regarding personal condition and treatment stands on the other side of the scale.

To be unique as a human is the third dimension of humanisation. The point is, that a human is "more than the sum of the parts", it is a part of something bigger and has something unique in that moment. By adopting a role or fitting into a particular group the person is transformed towards homogenization. Especially patients want to fit in, be a good patient and act along expectations.

To be part of a community means to be human. It means to be part of a continuous dialogue about similarities and differences of people and a process of how the information is processed in a unique and personal way. On the other side of togetherness is isolation which describes the feeling of being separated from others and the sense of belonging.

To care and see the meaning of things and (personal) life experience create humanisation. This means as well to create wholes out of parts in order to look for the

narrative truth. If this capacity is taken away, meaninglessness is spread. The feeling of being part of a cog of a machine supports the process, that human turns into a number or statistic.

To be on a personal journey means to be human. The present state of a person needs to be understood in the context and as a result of the past. The sense of continuity creates the feeling of being human and interconnected. By focussing on how a person is and not on who it is, a person can lose its personal story. Further, this loss can be created when "[…] individuals are oppressed by sameness, routine and repetitious activity" (Todres et al. 2009, 73).

The seventh dimension describes the sense of place. A personal place, home, which can be physical and emotional creates this sense. On the opposite side stands dislocation and represents the loss of this sense of place and creates a feeling of strangeness.

The last dimension is called embodiment and means that a human is living with physical psychological limits, which are a reminder of the personal potential. With this humanising perspective well-being makes life worth living and not just an absence of illness. This is different by a reductionist view of the body where the body is seen in its individual parts and separated from the environmental, social, psychological or spiritual context.

These philosophical dimensions have a strong focus on the basic human needs and elements of being, which is why they form the theoretical basis for other humanising processes, however this focus makes them as well an excellent basis regarding humanisation of healthcare (Todres et al. 2009, 69-74).

Todres et al. (2009) are not the only researchers who defined elements of humanisation or reasons of dehumanisation. The various scholars differ in their views,

focuses and in their goals. Whereas Todres et al. (2009) are creating a philosophical conceptual framework of humanising care to guide qualitative research and practise, Busch et al. (2019) are focussing on a systemic review of the existing concept of humanisation of healthcare, identifying elements and barriers by analysing the different stakeholders and formulating strategies for implementation adjusted on the different actors. Busch et al. (2019) point out, that the approach of humanisation of care is partly overlapping with other approaches like patient-centred and person-focused care. The patient-centred approach is an alternative to traditional models, which are based on paternalistic attitudes and disease-centred care. In the former, the patient is part of the decision-making process and its personal values and needs are respected. However, this approach is limited on the short episode of time or moment. Whereas, the person-focused care is considered as a more holistic approach, by seeing the story behind a person and respecting its uniqueness. Humanisation of care goes another step further and embraces these two approaches and includes different actors who are involved in the caring process and the relations, structures and aspects (Figure 1).
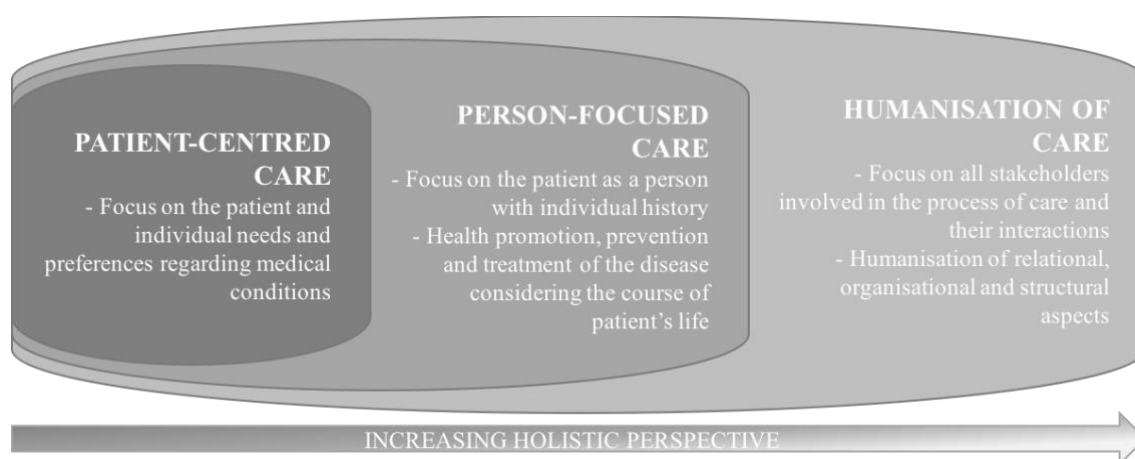
Figure 1: Development of the Different Approaches of Care

Source: Busch et al. 2019, 462, own presentation

Despite – or because of – the more holistic perspective and inclusive characteristic of humanisation, it still lacks in conceptual clarity and definability (Busch et al. 2019, 461-462). Without qualitative theories and research programs the present implementations of humanised care stay isolated practices (Busch et al. 2019, 462 and Todres et al. 2009, 76). Furthermore, the voice of different stakeholders within healthcare are relevant to analyse the key elements and barriers of humanised care. Busch et al. (2019) include in their study patients, patients' caregiver and healthcare provider and analysed within three areas – relational, organizational and structural - 30 elements. These elements are listed within the three areas and sorted by frequency in figure 2.

Relational Area Influences the relationship between patient and healthcare provider		**Organisational Area** Influences the work environment and the organisational practise	**Structural Area** Focus on the structure of healthcare institution and work environment
• Respect for patient's dignity, uniqueness, individuality, and humanity • Empathy towards the patient • Relationship bonding • Holistic approach • Respect for patient's autonomy and patient involvement • Verbal and non-verbal communication • Meeting patient's needs/ demands • Commitment • Moral and ethical principles	• Relational support for the patient and patient's caregivers • Being attentive/interested/ concerned towards the patient • Healthcare provider's competence • Patience • Transparency regarding the treatment • Fair-mindedness/equity • Healthcare provider's personal characteristics • Psychological support for healthcare providers	• Adequate working conditions • Adequate training • Team work • Continuity of care • Appropriate medical treatment • Organizational support for the patient and patient's caregivers • Facilitated access to healthcare • Vertical and horizontal communication • Pleasant hospital stay • Adequate priority assessment	• Human and material resources • Adequate physical structure • Pleasant environment

Figure 2: Key Elements in Relational, Organizational and Structural Area

Source: Busch et al. 2019, 467, own presentation

The seventeen elements in the relational area supporting the creation of a relationship between patient and healthcare provider, go along with the eight dimensions of humanisation of Todres et al (2009) (insiderness, agency, uniqueness, togetherness, sense-making, personal journey, sense of place and embodiment). Besides, that the relationship is a need of all three actors, it is also an important mean for establishing humanised and qualitative care. Besides the bond, between them were empathy, dignity, individuality, uniqueness and humanity mentioned as relevant elements. The respect of

the patient's needs, the inclusion in decision-making processes and the transparency of treatments are further elements of humanised care which create the feeling of autonomy. By "taking patients' preferences and needs seriously improves patient satisfaction, empowerment, quality of life, and treatment outcomes" (Busch et al. 2019, 471). Additional to the quality of work which influences the relationship between patient and caregiver are elements mentioned which only refer to the character of the caregiver and the support he/she receives. These additional elements emphasise the holistic and inclusive characteristic of this study.

Within the organisational area, the first five elements are related to the working environment of the caregiver and the quality of care. The lack of time, the routine at work, bureaucratic activities and additional duties beyond the scope are barriers of humanised care. To overcome these barriers, good working conditions need to be established and the well-being of the healthcare provider needs to be respected and supported. Further, trainings, team work and a vertical and horizontal communication are required for providing qualitative humanised care. Out of the patients' perspective, appropriate medical treatment, access to healthcare, continuity of care and organisational support were mentioned as relevant organisational aspects.

The third area, the structural one is talking about the resources (human and material), which are required to provide humanised care. A lack of material and human resources are linked to an increase of the stress level of care givers and their job satisfaction.

Because of the inclusion of the views of three actors within healthcare, this study is representing further important elements regarding humanised healthcare (Busch et al. 2019, 464-471).

This overview of humanisation of healthcare has shown that through a more general philosophical perspective the basic human needs and elements are in focus, whereas through the inclusion of diverse actors of healthcare more context-sensitive elements are considered.

The different scholars are on the same page, by saying, that there does not exist a clear definition of the concept of humanisation of care or childbirth specifically. Most of them are formulating a frame, elements or barriers to draw a picture of humanisation of care.

However, in the context of the Conference on Humanisation of Childbirth in Fortaleza, Ceará in Brazil, end of 2000 a definition of the concept of humanisation in general was formulated and adopted.

Humanisation is

"a process of communication and caring between people leading to self-transformation and an understanding of the fundamental spirit of life and a sense of compassion for and unity with:

1. the Universe, the spirit and nature;
2. other people in the family, the community, the country and global society; and
3. other people in future, as well as past generations

Humanization is an important means of encouraging and empowering individuals and groups to move towards the development of a sustainable society and the enjoyment of a fulfilling life. Humanization can be applied to any aspect of care, including childbirth, the terminally ill, the elderly, the disabled, the poor, health and disease, education, the environment, economics, politics and culture.

As childbirth is the beginning of life and affects the rest of life, and because the humanization of childbirth is such a clear need, the application of this particular aspect of care is an important start" (Umenai et al. 2001, 3-4).

For this thesis, this definition can only be seen as an additional rough frame to the other two perspectives highlighted before, in particular because context and time are influencing the characteristics of humanisation. Which is why the focus will rather be on elements which support humanisation of childbirth in Germany than orientating along one strict definition.

2.2. Humanisation of Childbirth

This chapter deepens the understanding of humanisation of care and is bringing it into a more specific context – childbirth. Humanised childbirth is the fundamental concept of this thesis. The ideas of how childbirth is seen, understood and should be transformed towards it are based on the concept of humanised childbirth a. Thereby, it is important to remember that the understanding of this thesis is influenced by peace studies and the cultural context of Germany.

Humanisation of childbirth arose out of the need to minimise the effects of the current activity and behaviour and to change the development of medicalisation, patriarchal and biomedical model (Curtin et al. 2020, 2).

The oxford dictionary is defining humanise as: "make something more human" and "give it a human character" (Lexico, 2020), which translates for the process of humanisation of childbirth into on the one hand to humanise the process and activities around childbirth and on the other hand to see childbirth as well as the women as human (Wagner 2001, 25). This would mean that it is partly a passive process, but this is not true. The different actors are taking an active role within this transformation towards a humanised childbirth.

Historically humanised childbirth has been associated with women who are classified as low and normal risk and experienced a natural birth with no medical

interventions. Apart from the fact, that natural birth is an elastic term, this has been criticised because this understanding of humanisation of childbirth is denying the women who need (some) medical intervention the possibility of a humanised childbirth. Especially, since the positive impact of emotional and mental support for women during pregnancy and childbirth is proven, the demand of identifying positive influencing procedures and behaviour of clinical staff grew (Curtin et al. 2020, 2). Not only women who do not need/want/receive medical interventions should benefit from humanised care. Curtin et al. (2020) underlines this argument by discussing, the unreasonable division of normal and high risk pregnancy, because both groups need and have the right to receive humanised care.

Humanisation is often seen as the opposite, an antithesis of technological medicine or the biomedical understanding of childbirth, but it can be understood in a similar way like dehumanisation. Both are on a scale with different degrees of medical and technological influence (Curtin et al. 2020, 5).

Humanisation has ambiguous understanding, which is why it cannot be limited to a set of tasks or elements. It is more a development in which all involved actors have their responsibilities and have to contribute to benefit from a clear understanding (Curtin et al. 2020, 17-18). Humanised childbirth has to be understood as a human experience, in which listing, receiving, creating bonds and providing guidance are the basic aspects of care. Childbirth as the beginning of life has to be "experience in a positive and enriching way" (Possati et al. 2017, 2). This goes often along with a woman centred approach, where the individual values, rights and beliefs of the women are guiding the procedure (Behruzi et al. 2013, 1 and Possati et al. 2017, 2). It means to support the women to trust and "believe in herself through experiencing what her own body can accomplish" (Wagner 2001, 31). This does not exclude the use of technology or medicine, if they are evidence-based and

give the woman more freedom and autonomy (Possati et al. 2017, 5; Wagner 2001, 25). The key is that the woman controls the birthing process. If the woman just has the control over certain procedures or decisions, the power will stay with the medical staff because they decide which choices are given. To be human means as well to have the right to err, and thus the woman and the doctor have this. But the woman has the right to err during her own birthing, not someone else (Wagner 2001, 26). Trusting in the natural procedure of birth and supporting the woman to experience this process, and not overriding and controlling biological procedures by using interventions, defines humanised birth (Wagner 2001, 26). Humanisation of childbirth offers the possibility to combine the advantages of western medicine and of the natural, biological, cultural, social and spiritual birth (Wagner 2001, 31). To respect the medical benefits as well as ones of the natural and cultural based birth is contemporary and underlines the request of a redefinition of the concept of 'natural birth' by the different actors of childbirth (Behruzi et al. 2013, 2).

Birth is highly cultural. Behruzi et al. (2013) are understanding childbirth in their article as an organisational cultural phenomenon, which is in a constant changing and developing process. They denounce that most studies do not respect and include the importance of the social and cultural norms, which are embedded in childbirth and the institutions (Behruzi et al. 2013, 2). In other words, the birth process "provides a structure around which social and cultural forces guide its expression" (Esposito 1999, 111) how Esposito a psychiatric mental health nurse practitioner argues. The impacts of these norms on the birth practise are often ignored. However, this social and cultural power is "[…] creating the potential for diversity in birth beliefs, practices, and experiences" (Esposito 1999, 111). The individual understanding of social culture, class and resources are influencing the personal cultural attitude about birth and its practice. Which is why, it is important to know the personal cultural understanding of the pregnant women and

cultural norms, which influence the institutions. The inclusion of the cultural norms within the study of humanised childbirth provides the possibility to understand the values and assumptions regarding medicalisation and humanisation (Behruzi et al. 2013, 4).

Few elements of humanised childbirth are repeated by all scholars in this field, regardless of the cultural settings. Firstly, the relationship between medical staff and the woman or rather to her and her family is important for a humanised childbirth. Through this bond, the capacities of communication, receiving, listening and providing are strengthen and the individuality of the woman and her needs, doubts, values and beliefs are respected (Possati et al. 2017, 2). The individuals are empowered through empathy, which supports the relationship between women and medical staff and the process of humanisation. Possati, a nurse and doula summarises it as followed: "It is empathy, when you put yourself in someone else's position. To think about what you would have wanted, to know what is important to her, what her feelings [are], to know she has a name, an identity, […]. We have to actually put ourselves in their place. How would we like to be treated at that moment? This is the most important thing, because we are so stuck to the routine and we end up not putting ourselves in their place and doing things automatically" (Possati et al. 2017, 4).

The second element is, the respect of various rights - human rights, women rights, respectful maternity rights and children rights - to create a stable and legal frame which protects the women and their children. By getting familiar with the international and national rights women are becoming active participants and can protect themselves (Curtin et al. 2020, 12-17).

Another element is, to promote evidence-based maternity knowledge, practises and guidelines to guarantee that every intervention is appropriate and essential for the

individual case and does not follow a routine behaviour. This goes along with the understanding of the impacts of care (Wagner 2001, 31).

The fourth element is that women have the control over their own body and birth to make sure that they are making their own decision and empower them to believe in themselves (Behruzi et al. 2013 1 and Wagner 2001, 31).

The last element is the responsibility of every actor within humanised childbirth. Medical staff need to be aware of their responsible and impact they have and women need an understanding about their rights and needs to protect themselves and actively shape their experience of humanised childbirth (Curtin et al. 2020, 17).

As already stated are the elements of humanised childbirth depending on the context and the cultural understanding of childbirth. Generally, is "the humanization of birth [..] about love between people, and it is the basis for love in the family" (Page 2001, 55). Since the understanding of love is as individual as peace, this chapter will end with no clear checklist but rather with a rough understanding of humanised childbirth.

The next chapter is talking about dehumanisation of childbirth, explaining the extent of its impact on women, children, medical staff and society and the created violence.

3. Dehumanisation of Childbirth

On the other side of the continuum is dehumanisation of childbirth, its elements and characteristics which will be explained in detail now.

"Dehumanisation is endemic in medical practice" and healthcare (Haque and Waytz 2012, 176). The heart of dehumanisation is, that a human is denied in its mind which consists of the experience to feel pain and pleasure and the capacity to choose and

plan. Either one or both of them are deprived from a someone else. Denying the experience of someone can be described as cold, passive, uncaring, superficial and like a machine. Whereas the description of coarseness, savagery and irrationality like animals arises by denying the capacity (Haslam 2006, 257; Haque and Waytz 2012, 176). The core of all conceptualisations of dehumanisation is the "diminished attribution and consideration of others' mental states" (Haque and Waytz 2012, 177).

Dehumanisation in the medical context does not need to arise out of malicious intention of caretaker. It is often a by-product of the hospital life with functional requirements and social practices. Haque and Waytz (2012) are discussing six major causes of dehumanisations which are: "deindividuating practices, impaired patient agency, dissimilarity, mechanization, empathy reduction, and moral disengagement" (Haque and Waytz 2012, 176). This means, that the patients become anonymised and are thus seen as incapacitated because of their suffering. Out of this perspective the differences between physician (medical staff) and patient are highlighted. Patients are defined as medical systems consisting interactive parts, not seen as social entities but as objects (Haque and Waytz 2012, 176-179). This process of dehumanisation in medicine is also affecting childbirth.

It is a process which started centuries ago, however, in the last thirty years the process of medicalisation accelerated this development and with this the use of medical technology and interventions which became the new norm in many western countries (Johanson 2002, 892). "Western, medicalized, high tech maternity care under obstetric control usually dehumanizes, often leads to unnecessary, costly, dangerous [and] invasive obstetric interventions" (Wagner 2001, 25). Dehumanisation affects both medical staff and patients and is seen as an inappropriate and unprofessional behaviour which can cause lasting harm to the patient, the women and the child (Kukura 2018, 754).

Dehumanisation is the basis of the institutionalisation and medicalisation in the medical context which is why these processes will be placed into the context of childbirth as well as analysed and discussed in the following subchapters. After discussing the overall concept of medicalisation, a general understanding of violence out of the peace perspective will build the second ground for the discussion of obstetric violence. Obstetric violence will be analysed along the three types of violence – direct, structural and cultural – and will be deepened on specific examples within these types. Before the impacts of obstetric violence will be presented, the influence of gender and international as well as national laws will be considered.

3.1. Medicalisation of Childbirth

The development of dehumanisation involved the process of institutionalisation which led to a medicalisation process (Jardim and Modena 2018, 2). This process is characterised by more interventions during labour, a hospital administration which is "seeking to maximize revenue and efficiency, further entrench the incorrect view that more intervention in the birth process is preferable because it increases safety without additional risk" (Kukura 2018, 769). This development brought significant changes like the "medicalization of the female body, promoting its defragmentation, depersonification and pathologi[s]ation, as well as generating the abusive use of unnecessary interventions on the women and infants" (Jardim and Modena 2018, 2). From now on the gestation was seen as a pathological event which requires control and healing. The women lost their pole position and were turned into a secondary element which needs to be controlled. They were segregated from their social context and denied from their capacity to give birth (Jardim and Modena 2018, 2). The birth has changed from an exclusive female and domestic topic to a man involved and patriarchal leaded event in the last three centuries.

This process is especially visible in the western word. In the beginning, men were only involved as obstetrics in difficult childbirth. A landmark for the era of obstetrics was the introduction of the forceps into the instrumental delivery. This was followed by the development of Caesarean section, safe blood transfusion, anaesthesia and medications in the 19th and 20th century in the western countries which resulted in a decrease of the maternal and infant mortality rates. Besides, this medical development influenced the control of diseases and family size and led to an improved style of living (Johanson 2002, 892). With the medicalisation starting in the 19th century, a process of hospitalisation and a mechanisation came along in the 20th century. It was and still is a complex process in which various drives are interconnected. On the one hand the medicalisation changed the health system and the obstetric supply structure, and on the other hand during the same time the self-determination of women in society and around birth rose as a by-product of the women's movements (Jung 2017, 31). During that time, the involvement and responsibility of obstetricians in normal birth procedure has changed completely. The normal birth, besides the complicated ones, became part of their duties. Especially the women who had an unobtrusive pregnancy and were not risk patients, experienced this development. The increase of unnecessary interventions is the main consequence of the medicalisation. Routine procedures like intravenous infusions and oxytocin to introduce and accelerate labour, a constant electronic fetal monitoring, epidural anaesthesia or a dorsal birth position became the norm. The common use of these medical interventions changed the general understanding of childbirth into a mechanistic, medicalised and universal procedure. One example is the electronic fetal monitoring via cardiotocography (CTG) which is now used with/at nearly every birth, is attributed as an essential component of spontaneous childbirth even though the significance and the positive impacts for labour are not proven (Johanson 2002, 892-893). Additional, the continuous

use of CTG increases the use of medical interventions and Caesarean section. Furthermore, it can hinder beneficial interventions like being able to change the birth position or to walk. The WHO is recommending not to use continuous CTGs during spontaneous labour (WHO 2018).

Because of the development of medicalisation, a significant deterioration of the quantity and quality of care is stated on the structural level, whereas the level of self-determination of the pregnant women and birthing mothers is rising. In the context of medicalisation, self-determination is often seen as a positive achievement for the women. However, it is handled in the way that the women are expected to prepare and inform themselves in order to make the right decision. The medicalisation is still not a good frame for a healthy self-determination of the women, because the effects of the economic and political structural deficits which result out of the medicalisation are invisible and the decisions of the women are made on basis of unknowingness (Jung 2017, 30-31).

1985 the WHO has described medicalised birth as a strange setting, where women are separated from their environment, surrounded by strange people and controlled by machines. The body and the mind of the women as well as the way of carrying are modified, which also influences the child. Further, it is stated, that the care providers do not know anymore how a non-medicalised birth would look like (WHO 1985 in Wagner 2001, 26).

Today there are three types of medicalised births prevalent. The first one is mostly spread in the USA, Russia, France, urban Brazil and Belgium is the "[…] highly medicalized, 'high tech', doctor centred, midwife marginalized care […]" (Wagner 2001, 26). The second one is "[…] the humanized approach with strong, more autonomous midwives and much lower intervention rates found […]" (Wagner 2001, 26) in the Scandinavian countries, Netherlands and New Zealand. The last approach is a mix out of

the other two and is mostly spread in Canada, Britain, Germany, Japan and Australia (Wagner 2001, 26).

Every change and every development has the potential of negative and positive effects. The positive effects cover the negative ones up to the point where the benefits reach everyone, then the negative mostly invisible ones will appear. The negative effects of medicalised childbirth and the interventions are emerging now. For example, the Caesarean section was a crucial point of decreasing the maternal and neonatal mortality rate, but today it is a common procedure for un-emergency births and has negative effects. Also in the USA, both the maternity mortality and Caesarean section rate are increasing again while in other industrialized countries the ratio is decreasing. There is no scientific evidence which justifies the claim to improve the medical situation to an optimum through high tech medicalised care in rich countries. The attempt to prove the positive correlation of the increased use of obstetric interventions and a decrease of neonatal mortality rate has failed. The process of medicalisation reached its tipping point, when the maximum of development and technology is reached and the negative effects appear (Wagner 2001, 26-27). "This helps to explain why advances in technology and in development cannot lead to improvements in health unless the technology is in harmony with natural biological processes and is accompanied by humanized health care" (Wagner 2001, 27).

Besides the effects of the routine technical procedure it is important to consider the social constructed gender of women to understand the phenomenon of medicalised childbirth and its effects. This feminist understanding results that women are "seen as the fragile sex, need to be kept under patriarchal authority (in this scenario, the physicians), who have the right to decide what is best for them, transforming the birth into a professional-cantered act and subject to violent practices" (Jardim and Modena 2018, 2).

The feminist perspective is important to understand the underlying social pattern, but has to be seen in the context of further perspectives, actors and cultural structures.

The unnecessary interventions, the routine, the abusive use of medicalisation, the inhuman treatment, the practise without consent, the discrimination based on culture, economy, religious or sexual orientation and the violation of human, women and maternity rights are all forms of obstetric violence (Jardim and Modena 2018, 8). This complex phenomenon is seen as a process and part of the umbrella term dehumanised childbirth. Which is why an in-depth analysis of obstetric violence and its different forms of violence, the influencing factors and the impacts are the object of this chapter will follow now.

3.2. Understanding Obstetric Violence

This chapter will present a comprehensive understanding of obstetric violence starting with violence out of a peace studies perspective and continuing with obstetric violence in the German setting. A fundamental understanding of violence is important to include obstetric violence into the peace studies context and assign the different examples of obstetric violence to the right type of violence.

3.2.1. Violence from a Peace Perspective

Violence is a complex and ambiguous phenomenon and is one of the "[…] most difficult concepts in the social sciences" (Imbusch 2003, 13). Violence is omnipresent, it is both intriguing and horrifying and can be found in every culture and society. On the one hand, violence gets easily mixed up with semantically-related concepts like power,

conflict or force, on the other hand it is a widespread idea and is used in daily conversations which makes a clarification so important (Imbusch 2003, 14-23).

Violence is not something, that always concerns the others, every one of us is in a way victim and perpetrator at the same time (Rauchfleisch 1992, 8). It is everywhere, on a small and large scale and on national and international levels. No region or society nor a culture is free of violence, which is why a differentiated and area orientated understanding of violence is important (Imbusch 2003, 13-14). Since this thesis is focussing on Germany, the German language and culture has to be part of the analysis of violence.

Peter Imbusch is a German sociologist and political scientist who focuses on theories and explanation pattern for violence and the semantic and linguistic differences regarding the concept. The complication of the understanding of the concept of *Gewalt* (German: Violence) in the German-speaking counties starts with its polysemy, in contrast to francophone, Anglo-Saxon and Ibero-American areas where *Gewalt* is limited in its precision. The polysemy is that *Gewalt* defines both the authority of the state and its institutions as well as the physical assault. The use and understanding of *Gewalt* has changed within the centuries from wield and dispose power to have power and control over something. In the ancient time, an important distinction was made by the Romans who grouped *Gewalt* into the same semantic group as government, rule and power. On the contrary, in the Anglo-Saxon areas there were similarities and semantic links between strength, power and power of attorney and injustice visible. Nevertheless, the definition of *Gewalt* in the German language represents an exaptation. In the end of the modern age, four meanings of *Gewalt* have been established in the German language (Imbusch 2003, 15-16). The first understanding defines *Gewalt* as a "power of public institutions connected to a legal system", the second as "value-free description of the territorial

authorities, the authority of the state, or their concrete representations", the third understands it as "relations of disposal or actual ownership" and the last one sees it as "the use of physical violence" (Imbusch 2003, 16).

To sum up, the concept of *Gewalt* has changed in its semantic from a relatively "restricted, concrete term for authorities, whose legitimacy is unquestioned, to a broad and relatively indistinct meaning of the term exhibiting considerable variance and also conveying various different normative and descriptive components" (Imbusch 2003, 17) in the German-speaking countries.

Besides the differences in the language, Imbusch discusses the different strands of meaning of violence which can be deduced through seven questions underlying the semantic distinctions and the diversity of this concept. Starting with the question of "Who exercised violence?" one can find out the perpetrator(s), the subject, the agents as individuals, groups, institutions, organisations, or structures in an abstract way. The second question "What happens when violence is exercised?" is asking for the facts of an action, the spread, the effects, the scale and the intensity of violence. It demonstrates that violence has a particular space and time and not an unlimited growth. The ways and means in which violence is exercised is the core of the third question "How is violence exercised?". The answers clarify whether physical or psychological violence or symbolic or communicative violence is used and outset by a single individual or a group, organisation or structure. The fourth question is asking to whom the violence is directed at and is focusing on objects of violence, the human victims who suffer from violence. The last three questions are why questions and they are asking for the reasons and causes, the interests and possibilities, the objectives, the motives and goals, and finally for the justification of violence (Imbusch 2003, 14-22).

These questions are independent of definitions or types of violence. They are helping to complete the picture and to understand the complexity of violence in a specific time and place. To distinguish the different types of violence like direct (physical and psychological), structural and cultural, it is important to differentiate the various meanings and semantic of the concept (Imbusch 2003, 23).

Since the semantic differences are clarified, the diverse meanings and dimensions, a definition of violence is needed. There are many definitions which are different in their complexity, profundity, inclusion and exclusion of understanding of the concept of violence. Rauchfleisch (1992) for example defines violence as a specific type of aggression, which is targeted action in form of exercised or threatened physical or psychological aggression against an object or subject. Violence goes along with a relative power (Rauchfleisch 1992, 11).

The basic understanding of violence as a form of aggression is one sided and does not fulfil the complexity of the concept. Furthermore, the structural dimension of violence is not covered which is why a wider and complex definition is needed. The definition from Galtung provides this complexity and the needed generality to meet the discussion of this thesis. Galtung says, that "[v]iolence is any avoidable insult to basic human needs, and, more generally, to sentient life of any kind, defined as that which is capable of suffering pain an enjoy well-being. Violence lowers the real level of needs satisfaction below what is potentially possible. Violence to human beings hurt and harm body, mind and spirit" (Galtung 2013a, 35). Especially that violence result in trauma, deep wounds, emotional and cognitive distortion and spread a feeling of hopelessness (Galtung 2013a, 35) are important effects which have to be respected within the understanding.

Besides Galtung's definition his understanding of the three forms of violence - direct (physical and psychological), structural and cultural violence –will be used as a

guideline for the categorisation of the different examples of obstetric violence in this thesis.

The three forms within the triangle of violence are interconnected with a causal interconnection but can also operate independently. Even though the triangle always stays a triangle, the interdependency can be interpreted in different ways when changing the order. Structural and cultural violence can – for example – be understood as the legitimation of direct violence, however this is only the fact with this specific order (Galtung 2013a, 46). Nevertheless, "a causal flow from cultural via structural to direct violence can be identified" (Galtung 2013a, 47).

One general difference between the three types is their time relation: Direct violence is an event whereas structural violence is an (changing) process and cultural violence is an ongoing transformation of the common culture (Galtung 2013a, 46). The clear difference between these three types is notable by discussing the various examples of violence. Concluding, violence can start in one of the three corners of the triangle, but when structural violence is institutionalised and cultural violence is lived, direct violence becomes accepted and part of normality (Galtung 2013a, 58).

Closing, the semantic explanation characterised by the German culture and language, as well as the definition and types of violence from Galtung are creating a broad and specific baseline to look at obstetric violence from a peace perspective.

3.2.2. Obstetric Violence – Concept and Language

Obstetric violence is existing all over the world, it is not a new phenomenon but neither is it common knowledge. The German context is helping to localise obstetric violence and to understand local pattern and characteristics.

Childbirth is not often associated with violence, unless the natural violence of the body, the power of the woman and the physiological process of parturition are addressed. Violence in the context of childbirth on the other hand, which is external and not natural, is a tabooed topic in the German society. If this type of violence is at all part of the German birth culture is depending on the angle of view. The modern perinatal medicine is a great achievement, the clinics are modern, need-orientated, friendly, have a high scientific standard and qualified staff. Germany can show a positive and remarkable development in the perinatal medicine, however, childbirth is much more than a rational medical process. No other life moment has a bigger biographical impact on psychosocial, emotional and physical processes than the childbirth, which is why a different benchmark in our possibilities regarding the development and a new perspective for a birth culture is needed. Childbirth is not only a medical-scientific process, it is also a part of our society and a cultural asset. With the rapid development in scientific thinking and medical scope of action during the time of enlightenment, a change of the paradigm of a natural and traditional obstetrics happened. The paradigm shift lead to a medical guided midwifery which felt to be able to handle obstetric complications through medical interventions. With this development, physicians became part of the team in the delivery room and a change of thinking happened. The birthing mother and her child were now seen as potentially sick rather than potentially heathy. This different understanding of the salutogenetic approach of midwifery, which sees the birth as a natural event, clashed and still clashes with the pathogenetic approach of medicine which wants to medically control birth. These two understandings are not just a disagreement, they are part of an old attitude of matriarchal and patriarchal thinking (Hildebrandt 2012, 109-111).

Since every birth has its individual character, its unique constellation between the actors and the subjective perception of violence as well as the unknowingness of the

necessity of medical interventions, it is hard to generalise obstetric violence. However, the effects of violence in direct and indirect ways are visible. After this violence is spread worldwide and not connected to individuals, it cannot be seen as a coincidence (Mundlos 2015, 35).

The terminology and definition of obstetric violence has been highly discussed in the literature for the last two decades (Savage and Castro 2017, 3). Till now, there is no universally adopted understanding of this discourse let alone a definition or fixed term (Kukura 2018, 728). Terminologies like disrespect and abusive care, discrimination and mistreatment, obstetric violence and dehumanised birth or respectful maternity care, maternal healthcare and humanisation of childbirth are dominating the research. On one side, these terminologies are partly used interchangeably whereas on the other side nuances of differences and perspectives are recognised and discussed (Savage and Castro 2017, 3-4).

The phenomenon itself is older than the discussion of the terminology. Already in 1985, the World Health Organisation (WHO) was concerned about the excessive medicalisation of birth and demanded an "appropriate use of technologies for birth […] to review protocols […] and investigate the relevance of certain practices" (Sadler et al. 2016, 47) and promoted "respect for women's autonomy" (Sadler et al. 2016, 47). The proposal was to reduce interventions by means of legal clarifications, adherence of the rights and an informed consent (Sadler et al. 2016, 47).

The field is still evolving which becomes visible in the uncertain definition, various terminologies, changing or absence validated measurements and tools in research projects and actions (Sen et al. 2018, 6).

The reasons for the difficulties in finding a conceptual definition within this field are first and foremost the diversity of stakeholders. With this diversity, a variety of

perspectives and focuses are going along. Each stakeholder, being a feminist and human rights activist, international institution, politician, pharmaceutical company, medical staff or parent, has its own focus and includes as well as excludes different aspects. Whether human rights and bodily integrity, norms and standards, development goals, maternal mortality, work conditions or professional expertise, all of these elements are legitimate reasons to research and act on.

The second reason goes hand in hand with the first one claiming that the subjective perceptions of the women, the behaviour and practices as well as the normative standards of medical staff are difficult to merge (Sen et al. 2018, 7). Each term tries to demonstrate neutrality and openness, but it needs to be seen in its historical context and put into a critical classification of what is getting included and excluded, up- and downgraded or ignored within this perspective (Sen et al. 2018, 7).

The terminologies and different measurements are influencing the methodology, results and action of the research projects which is visible in the three different studies from Bowser and Hill (2010), Freedman and colleagues (2014) and Bohren and colleagues (2015).

The analysis of Bowser and Hill (2010) as part of a research project of the USAID (United States Agency for International Development) developed a list of different types of disrespectful care which include the following: "Physical abuse, non-consented clinical care, non- confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities" (Bowser and Hill 2010, 3). Since then this list forms the basis of diverse research projects, publications and statements of the WHO. The White Ribbon Alliance used this list of disrespectful care for their Respectful Maternity Care Charter: The Universal Rights of Childbearing Women in 2011, which will be further addressed in chapter four. Although

this list partly shows the diversity of disrespect, abuse and direct violence, the structural dimension is left out which is why it only functions as an orientation for this thesis.

Meanwhile, the concept of Freedman and colleagues (2014) includes the differentiation between disrespect and abuse from the individual, structural and policy level as well as the influence of inequality and uneven power structures to define abusive and disrespectful care in childbirth. This abstract framework is a good starting point for research and action but needs to be deepen the views of the women and of the medical staff, the drivers and consequences of disrespectful maternity care as well as for theories of changes (Freedman et al. 2014, 915-916).

The last example from Bohren and colleagues (2015) underline the limitation of Bowser and Hill's list and build up on their ideas to create a system of classification to compare and standardise mistreatment of women (Bohren et al. 2015, 21-23). Additionally, they include the factor that mistreatment can be an intentional and unintentional action from medical staff or health systems, which reflects the structural element within this phenomenon (Savage and Castro 2017, 5). These studies show how complex this phenomenon can be discussed, researched and understood.

This thesis will follow the terminology of obstetric violence, humanisation and dehumanisation of childbirth which has its origin in Latin America. Since the 1980s the research has focused on mistreatment, abuses, unnecessary medical interventions like C-sections and episiotomies as a form of violence and over-medicalisations in Latin America. Furthermore, institutional and structural violence which point out gender inequalities as well as power relations in healthcare were/ are part of the understanding of obstetric violence (Savage and Castro 2017, 5; Sen et al. 2018, 7). This term was introduced to "be recognised in laws on violence against women and by statutory human rights bodies" (Sen et al. 2018, 7). Venezuela was the first country which defined obstetric

violence and passed "through the Organic Law on the Right of Women to a Life Free of Violence" in 2007 (Sadler et al. 2016, 50). This law defines obstetric violence as

> "the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanising treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life" (Sadler et al. 2016, 50).

This definition enables to concentrate on the obstetrical and gendered dimension of this violence, the power within medical hierarchies and the medicalised childbirth from a broader perspective than only from 'mistreatment' or 'abusive care' (Sadler et al. 2016, 49-50). This discourse understands that women's human rights are enmeshed with power inequalities, interactions between patient and provider, institutional obstetric practice and with the inequity between marginalised and empowered groups (Sen et al. 2018, 7). It allows to use and include, besides the physical and mental, the structural dimension into the analysis which focuses on inequalities and social power structures within violence against women (Sadler et al. 2016, 49-50). Furthermore, obstetric violence considers routines and intensive use of practices within the institution which underlines the various need satisfaction between medical staff and institution and women (Sen et al. 2018, 7).

Researchers and medical staff have struggled with this term because of the possible interpretation of the blame to healthcare providers. However, mistreatment or abusive care are not reflecting the diverse aspects of violence (Savage and Castro 2017, 6).

Therefore, Sadler and scholars (2016) are promoting a linguistic change from mistreatment, disrespect or abusive care to obstetric violence to express the intensity of the problem within the Anglophone and Francophone research. They argue that obstetric

violence can address the multiple dimensions of violence during childbirth, especially the structural one (Sadler et al. 2016, 48). This thesis will follow these ideas and will use obstetric violence as the relevant term since the structural aspect is relevant for an analysis of childbirth in German hospitals.

Generally, obstetric violence is violence in the labour room towards the labouring women. This phenomenon is different to other forms of medical violence. The women report a loss of control, emotional and physical infantilisation, diminishment of self and shame (Shabot and Korem 2018, 1). The negative effects of obstetric violence are similar to misogynous violence. The rights are not communicated or ignored, the physical and psychological freedom and integrity of the women are deprived and they are reduced in their human capacity (Mundlos 2015, 32).

Concluding, violence of obstetric violence is generally understood along Galtungs (2013) definition in this thesis. Because this type of violence disrespects the basic human needs of women in labour, it minimises their level of need satisfaction and creates a feeling of loss of control, diminishment and shame. Furthermore, obstetric violence harms body and mind of women, creates physical and psychological wounds as well as traumas and the feeling of hopelessness. This goes along the definition of Galtung as discussed in the previous chapter.

The complexity of the phenomenon in this analysis is also a challenging factor, which is why the triangle of violence of Galtung will be used to structure, categorise and contextualise the examples of obstetric violence. Even though every categorisation brings along a degree on simplification, it is necessary to classify the different types of violence. The given characteristics of the triangle of violence can reflect and underline the intertwining relationship of the different examples of obstetric violence and makes it a good frame.

3.2.3. Direct Violence

Direct violence is directed against a person or a group, it is intentional and aimed to hurt, injure or kill. It is a course of action that can be used anywhere, at any time and does not require instruments (Fischer 2013, 11 and Imbusch 2003, 23). Researchers distinguish between two types of direct violence (also known as personal violence): (i) direct physical and (ii) direct psychological violence.

3.2.3.1. Physical Direct Violence

In the context of obstetric violence, direct violence comprises all unnecessary medical interventions with no significant medical benefit. Examples are episiotomies, manual openings of the uterine orifice, unnecessary inductions of birth with oxytocic agents, limitations of freedom of movement or caesareans. In general, unnecessary medical interventions are considered as violence when they are carried out too early, no necessary indication exists, they are not following common practice, patients are not informed about the procedure and their rights as well as when there is no consent to this intervention (Mundlos 2015, 37-49).

The following three sections will focus on specific examples of physical direct violence. The discussed examples play an important and dominate role in the German obstetric violence discourse.

Physical Abuses

All of the following types of physical violence are seen as violence if they happen without medical indications, the consent of the mother was not given or if they do not follow

standard procedures but are instead driven by external, non-medical indicators like time or money.

Time pressure leads to harmful routines and an increasing use of medical interventions like inductions of labour, the horizontal birth position or the Kristeller manoeuvre. This can lead to a cascade effect, implying more interventions and complications, which, in turn, require more professional control (Diniz and d'Oliveir 1998, 39). This effect is often the origin of physical assaults and abuses in German hospitals.

Starting the birth process with the induction of labour, which is done in more than 20% of all childbirth cases in Germany in 2016 (98% of these cases are induced through medications), a cascade effect with other interventions follows in most of the cases (IQTIG 2017, 60).

An example of a cascade effect is, if a woman receives an induction of labour too early and the cervix is not ready yet. It thus needs longer to open up and has to be monitored by means of the CTG. This limits the freedom of moving for the mother. If the contractions do not start after the first indication, the opening of the amniotic sac and/or an intravenous medical induction with oxytocin treatment are usually the next steps. A side effect of this medical treatment is that the following contractions are more intensive than the regular ones. Consequently, the women are so exhausted and tiered that another intervention, an epidural anaesthesia, is often necessary to relieve their pain. It is rather common that women who got an epidural anaesthesia do not feel the urge to push and press, which lengthens the last stage of birth. In this case, it can happen that the heartbeat of the child goes down which, in turn, raises the pressure to respond with a vaginal operation like an episiotomy, the use of forceps or a secondary C-section (Mörath 2014, 51). This is an example of a cascade effect when an induction of labour was induced too

early. The length of an induction plus delivery is in most cases longer compared to a procedure of labour without external induction and includes hours of contractions. Moreover, the women are physically and mentally more exhausted than during a delivery without an external induction of labour. In 50% of all inductions, the induction of labour is done too early. In other words, every second externally induced procedure of labour commences before the body has started the own procedure of labour (Rath and Zahradnik 2004, 246).

Another aspect concerns the timing of giving birth. Only 3-4% of all babies are born on the expected delivery date in the 40th week of pregnancy. This suggests that the delivery date should rather be seen as a period between the 38th and 42nd week in which the baby can be born, and not as a precise date. If there is no medical reason, an early induction of labour should not be conducted (Mörath 2014, 51). The available statistics on inductions of labour reveal that 30% of all inductions are based on soft medical justifications and take personal matters into account. Furthermore, 60% are based on classical indicators like Preterm premature rupture of the membranes (PPROM) or the woman being beyond the 42nd week (IQTIG 2017, 60). Different studies make different recommendations regarding an exceeded deadline over the 42nd week. For example, the American Congress of Obstetricians and Gynaecologists says that a wait-and-see attitude until the 43rd week is possible and does not increase the neonatal morbidity. Other scholars disagree and claim that the risk of mortality for the child is six times higher after the 41st week. More research needs to be conducted to come to a final conclusion. Until then, a risk-benefit ratio and a strict and regular inspection of the heartbeat of the child during these last days is recommended (Rath and Zahradnik 2004, 246).

As the induction is not necessary from a medical perspective in many cases, the induction itself and the interventions that can follow are seen as violence in these

instances. This view is justified as a premature induction often results in an unnecessary extension of being in labour and an intensified accompanying physical and mental exhaustion.

There are two other examples of physical violence that can be either part of a cascade of interventions or happen independently.

The first one is the Kristeller manoeuvre (uterine fundal pressure). It uses a "fundal pressure, i.e. a doctor or nurse push[es] on the abdomen to speed delivery" (Diniz and Chacham 2004, 102) in the second stage labour. It was developed by a German Gynaecologist, Samuel Kristeller, in 1876 to support the birth process from outside. Kristeller suggests to use the hands to apply a slowly increasing pressure on the fundus (upper end of the uterus). He emphasised that a moderate realisation is important (Kemper 2014, 228). The Kristeller manoeuvre is seen as a type of physical violence for the following reasons: the advantages of it are not scientifically confirmed, the handling is not standardised, it often involves complications and consequences for the mother and the child are high. If the manoeuvre is forced, too extensive or too early, a number of intrapartum complications have been reported:

> "[…] contusion of the uterus and peritoneum, premature (intrapartum) abruptio placentae, rupture of (non)cicatricial uterus, lesions of abdominal organs (rupture of the liver, omentum, stomach), and in the child fracture of the femur and other bones, asphyxia, peripartal death, intracranial and subgaleal haemorrhage, umbilical compression, alteration in the intervilous circulation with possible fetomaternal micro (macro) transfusion and possible (transient) throphoblastic or amniotic microembolism, and child visceral lesions. Rib and sternum fractures, higher incidence of third- and fourth degree perineal lacerations and hematomas of the anterior abdominal wall […]" (Habek, Bobić and Hrgović 2008, 185).

These numerous possible complications show the risks of this procedure. It should only be applied if a number of preconditions are satisfied. The conditions for carrying out a Kristeller manoeuvre are a fully opened cervix, regular contractions and the head of the child has to be in the right position on the pelvic floor (Kemper 2014, 228).

The current discussion on the Kristeller manoeuvre is controversial, especially because the procedure is already forbidden in some countries like France. In line with this, a number of textbooks recommends not to apply the procedure (Kainer 2016, 238). The discussion is about three main points: firstly, about the insufficient explanation and documentation in the literature, which makes an investigation and research about it hard. Secondly, due to the lack of clear instructions, a standardised technique is missing, which bears the risk of carrying out the manoeuvre wrongly. For example, sometimes the forearm with the pressure of the whole body is used instead of the hands. This is more painful for the woman and is associated with a higher risk of complications. Thirdly, randomised controlled studies are missing to evaluate the use, the benefits and the unintentional occurrence of side effects of a Kristeller manoeuvre (Kemper 2014, 229-230). Two conclusions from this discussion so far are that on the one hand, the women and the children do not benefit from this manoeuvre and it is connected with a higher chance of complications at the soft tissues. On the other hand, it also does not shorten the delivery stage (Schulz-Lobmeyr et al.1999, 560). Hospitals do not have to document the frequency of the Kristeller manoeuvre. This means that there are no statistics on how frequently it is used (Kainer 2016, 240). Current evident suggests that if women would give birth more often in a standing, squatting, in all-fours position or under water, the rate of the Kristeller manoeuvre, and consequently the amount of complications, would drop dramatically (Kainer 2016, 240).

This brings us to the second example of physical violence, the position of the women during labour and birth. A study from 2001 shows that among 1,009 women a majority of over 67% chose the supine position, whereas 16% decided for the lateral position and 17% for the upright birth position. A connection between the birth position and the occurrence of childbirth injuries as well as to the condition of the new-born could not be observed. The study shows as well, that the use of oxytocin and the occurrence of episiotomy is significantly higher for women who deliver in supine position (Bodner-Adler et al. 2001, 766-767).

Another study from Sweden focuses on the emotions of the women in the different birth positions and finds that the women who give birth in their preferred birth position felt more powerful, protected and self-confident than women who were not asked about their preferred position or were forced in a birth position. The own choice about the preferred birth position has an effect on women's emotions also results in less fear of childbirth. If the midwife supports the woman to choose her own preferred position, she promotes the woman's feeling of self-empowerment, which also strengthens her autonomy (Thies-Lagergren et al. 2013, 3-5). However, the back-laying position (supine position) is still the most common and used position, because the medical staff has a better view and more flexibility to monitor labour (Mselle and Eustace 2020, 1). This position was introduced in different European countries and their colonies during the 1800s, when surgeons became part of the maternity care (Reid and Harris 1988, 1993-1994). It is now seen as the "universally known and practised birthing position" (Mselle and Eustace 2020, 1) and often called the traditional birth position. This is quite misleading, as the supine position is only 150 years old, whereas the 'alternative' positions are much older and are still the norm in many parts of the world (Reid and Harris 1988, 1993-1994).

The birth position is considered as physical violence if it is forced and not in line with the preferences of the woman. A wrong birth positon limits the freedom of movement of the woman.

In addition to all the discussed forms of violence, the use of force against women, for example by tethering up, holding down or pushing the legs apart are also seen as violence. These physical abuses happen frequently and are seen as a standard procedure (Bohren et al. 2015, 7).

The next two section will address the phenomenon of the rising rate of C-sections in Germany and the discussion about episiotomies.

Caesarean Section

When C-sections are not only a solution for emergencies, a thorough analysis is important to understand the development of an increasing rate of C-sections in the modernised and medicalised obstetrics. In this thesis, C-sections are considered as one form of direct violence when no medical necessity is given, the consent and the maternity right of the mother are not respected or external factors influence the decision-making process of medical staff and mothers. This is why this section includes an in-depth and diverse analysis about C-sections.

The medicalisation of childbirths provoked a deprivation of women's natural ability to give birth and their right to a self-determined birth (Albrecht-Engel 2018, 53, Montiel 2017, 79). It further led to a rising rate of C-sections, which are no longer seen as an emergency procedure but a legitimate and well-established way of childbearing (Kolip, Nolting and Zich 2012, 9).

Especially the high rate of C-sections, which was over 30% in Germany in 2010 (Kolip, Nolting and Zich 2012, 6), is discussed in this section. The focus is on the factors,

which are driving this high rate. The data on the rate of C-sections and the neonatal mortality rate come from the WHO European Health Information Database (WHO 2020). This data allows a comparison between different European countries.

Comparing Germany to the other 14 European Union member countries, who were part of the European Union before 2004 and have similar medical and economic standards, reveals that Germany is not a pioneer in a low C-section rate (Figure 3). Out of this group of countries, only Italy has a C-section rate of over 30% in 2004. Countries, which entered the EU after 2004 and were part of the former eastern bloc, had a similarly high C-section rate of over 30%. Also Turkey, which wants to become a European Union member state has the highest rate of C-sections with 47% within the geographical European comparison during that time.
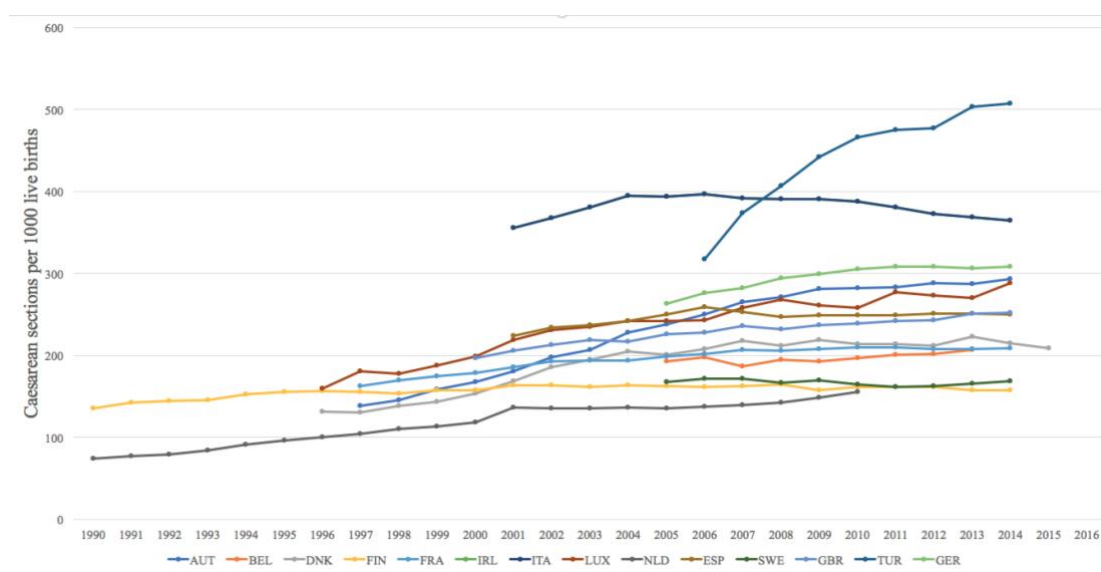
Figure 3: Caesarean Sections from Western European Countries

Source: WHO 2020, own presentation

The C-section rate stands often in relationship to the neonatal mortality rate, because the mortality rate could be reduced through better hygiene, medical infrastructure and emergency medicine. The neonatal mortality rate dropped from 14.31 to 3.7 deaths

per 1000 live births within the first 28 days, which can be explained through the medical progress in Germany between 1970 and 1985. In the following period and until 2012, this rate decreased further to 2.19. This slower decrease in the later years is understandable, given that the hygiene and medical care standards were already high and the medical infrastructure was much improved (Kolip, Nolting and Zich 2012, 6; WHO 2020). However, in the same period the C-section rate has doubled to 30% and is still increasing (Statistisches Bundesamt 2019, 34). This shows that the C-section rate and the neonatal mortality rate do not follow the same trend.

The relationship of the neonatal mortality rate and the C-section rate is visualised in Figure 4 as a snapshot for the year 2012. It includes two parameters, first, the caesarean rate per 1000 live births (percentages per 1000 live births) and second, the neonatal deaths per 1000 live births for the 15 European Union member states before 2004 and the average of the European Union.

This figure supports the argument that the C-section rate and the neonatal mortality rate are not positively correlated in the lower range of the neonatal mortality rate.

Within this group of countries, the neonatal mortality rate ranges from 0.8 to 2.85 and the C-section rate ranges from 16.1% to 37.7% in the same year. The neonatal mortality rate includes a smaller range, whereas the difference between the maximum and minimum C-section rate is rather large. The European Union member states have an average rate of the neonatal mortality of 2.56, which corresponds to the last third of the selected group and an average of C-sections of 26.8% which complies with half of the countries. Compared to the average of all European Union member states, Germany has a higher C-section rate (30.8% to 26.8%) and a marginally lower neonatal mortality rate (2.19 to 2.56) for 2012 (WHO 2020).
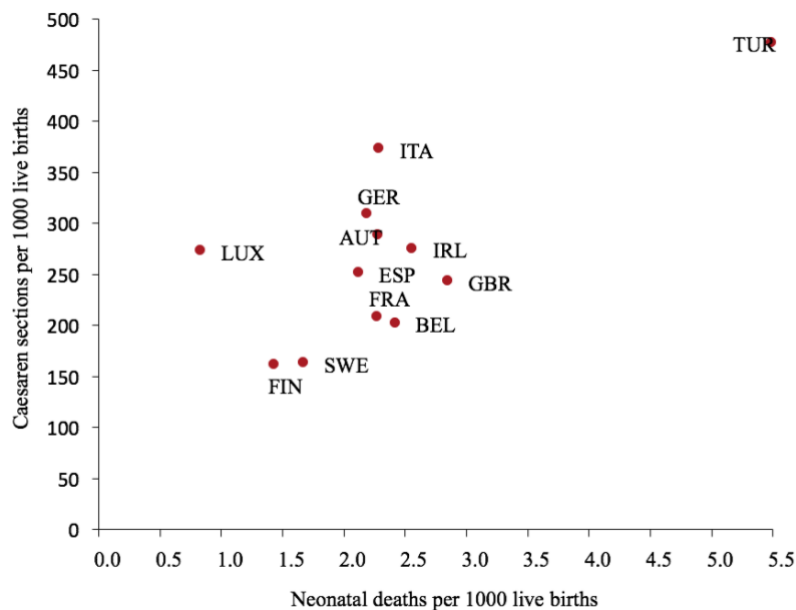
Figure 4: Caesarean Sections and Neonatal Deaths in 2012

Source: WHO 2020, own presentation

There are few cases where a decrease of the neonatal mortality rate occurred simultaneously with a small increase of the rate of C-sections. Finland is one of the examples (Figure 4 and 5) which exhibits no extensive growth in the C-section rate during the period where a reduction of their mortality rate can be observed. Finland had a C-section rate of 13.5% and a neonatal mortality rate of 3.73 deaths per 1000 live births in 1990. Over the next ten years, Finland experienced a small increase in the rate of C-sections to a value of 15.7% and a decrease in the neonatal mortality rate to 2.4 deaths per 1000 live births. Another ten years later, the C-section rate had increased again marginally to 16.1% and the neonatal mortality rate had declined by 0.91 percentage points to 1.49. This example shows that a reduction of the neonatal mortality rate does not necessarily have to coincide with an exponential growth of the C-section rate (WHO 2020).
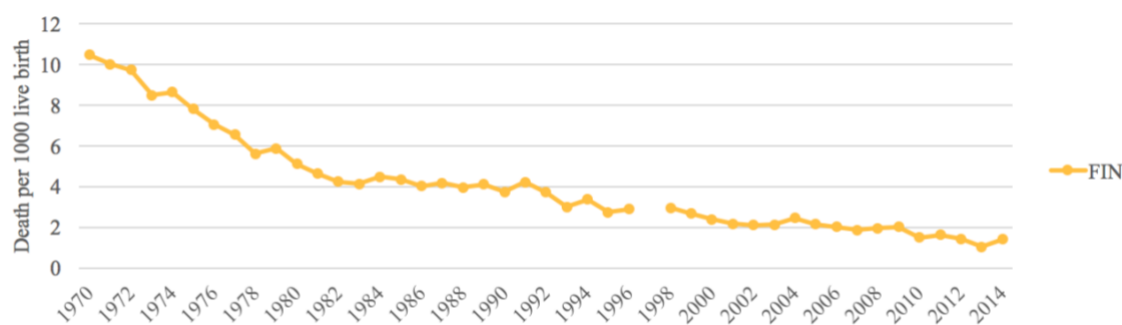
Figure 5: Development of Neonatal Deaths in Finland

Source: WHO 2020, own presentation
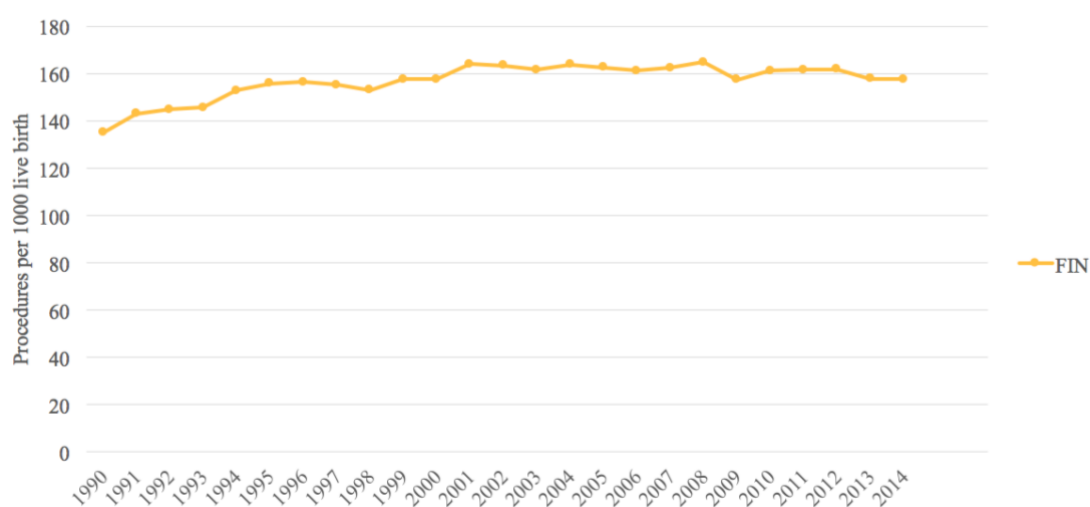
Figure 6: Development of Caesarean Section in Finland

Source: WHO 2020, own presentation

The evolution of the C-section rate has led to different studies and eventually new guiding principles in 2020 from the German Association of Gynaecology and Obstetrics (DGGG). The largest study was conducted by the Bertelsmann Foundation in 2012 and analyses the development and the regional distribution of C-sections in Germany. This study discusses and analyses the different reasons for the increasing C-section rate. The authors arrive at the conclusion that the main reasons for the observed increase are not the ones commonly discussed - like the increasing average age of the mothers, the increasing weight of newborn children, the higher number of multiple births or the wish

for a caesarean. Instead, the authors identify the changed handling of obstetricians with these situations and the structure of the procedures in hospitals as the driving factors behind the development (Kolip, Nolting and Zich 2012, 6). The following five points will demonstrate other factors, which affect the increasing C-section rate.

First, the hypothesis that C-sections are profitable cannot be generalised because the diagnosis-related group (DRG), case related fees, which is a lump sum accounting procedure in the hospital, are working against cross-subsidisation. Nevertheless, the type of hospital (private or public) and its cost efficiency influences the profitability of a planned C-section and a natural birth. However, a planned C-section can be better integrated into the organisational procedures of the hospital and is therefore more attractive for hospitals (Kolip, Nolting and Zich 2012, 6).

A result of this optimised procedure is the subject of the second point of the discussion: a time controlled birth plan. This leads to more births during the week and disproportionally many births on Fridays, compared to the weekend. This pattern arises because births are accelerated or decelerated through medical interventions to match a 5-day week (Mundlos 2015, 42-43). Furthermore, the opportunity to control the birth date plays into the hands of the hospital administration and the health policy, which follow a course of understaffed delivery rooms and efficient cost management (Abou-Dakn 2018, 234-237). This is problem plays also a role in structural violence, which is why it will be picked up again later in this thesis. The controlled procedure is not only influencing natural childbirths but also primary (planned and initiated C-sections before labour) and secondary C-sections (when there is an emergency or when the birth process has changed and the maternal and neonatal health is in danger). 88.4% of all primary C-sections were implemented during working days between 7 a.m. and 6 p.m., whereas primary C-sections, which to place outside the usual working hours and on the weekends, only

account for 10% of all primary C-sections in 2011. These numbers illustrate that the majority of C-sections is planned and coordinated and is not due to emergencies. Further, that secondary C-sections slightly dropped in comparison between working week (40.9%) and weekend (27.2%). This demonstrates that secondary C-sections, which are only conducted in an emergency, occur independently from working hours (Kolip, Nolting and Zich 2012, 22).

In addition to the planning aspect, the scope for action and decision-making process regarding C-sections represent another relevant point (point 3). They are crucial factors for the justification of C-sections and usually depend on absolute and relative indicators. 9 out of 10 decisions for initialising a C-section are based on relative indicators. Relative indicators are chosen on a case-by-case basis and leave a lot of room for individual interpretation. These relative indicators are subject to the discretion of the attending physician and do not follow a clear standardised procedure (DGGG 2020, 25; Kolip, Nolting and Zich 2012, 18-19). The most common relative indicators are previous C-sections (23.6% of all C-sections in 2010), pathological CTG (20.8% of all C-sections in 2010), prolonged birth, obstructed labour or maternal exhaustion (16.4% of all C-sections in 2010), breech presentation (5.5% of all childbirth are breech presentation, 87% are C-sections; 13% of all C-sections in 2010) (Kolip, Nolting and Zich 2012, 18-19), fear of childbirth and Caesarean delivery on maternal request (CDMR, 6.7% of all C-sections in 2005) (DGGG 2020, 50). When there is a high risk to the life and health of the mother and/or the child, the absolute indicators guide the decision for a C-section. Examples for these kinds of situations are placenta praevia (malposition of the placenta), HELLP syndrome (hemolysis, elevated liver enzymes and a low platelet count), which is a form of a pre-eclampsia or eclampsia, umbilical cord incidents or fetal acidosis (oxygen undersupply for the fetus) (Kolip, Nolting and Zich 2012, 17). In total, in less than 10%

of all C-sections, the decision was taken based on these absolute indicators (DGGG 2020, 25). This suggests that the decision for a C-section is less depend on the existence of an emergency than on a constellation of influencing factors like the time, stress, staff capacity, the region of Germany and the training of the obstetrics and physicians.

The last two factors which influence the decision-making process are the points four and five. The share of the caesarean varied in 2010 between 17% and 51% across different regions in Germany (Kolip, Nolting and Zich 2012, 7). Thereby the age distribution, the sociodemographic factors or the insurance status (public or private) have no relevant impact. The amount of the obstetrics` and physicians` trainings on the other hand can be considered relevant. A risk-averse behaviour of society and the decreasing experience of obstetricians in the field of difficult childbirth care like breech presentations, result in a faster decision towards a C-section and constitutes the fives reason (Kolip, Nolting and Zich 2012, 7). Four percent of all single pregnancies are breech presentations, which make up 12% of all C-sections and 90% of all breech presentations are ending in a C-section. The caesarean was for a long time the standardised procedure in case of a breech presentation, however the new guidelines argue that there are no medical reasons for preferring one birth procedure. The quality and the specialised infrastructure of the hospital which is given in nearly all German hospitals are important, as well as the experienced staff which have to be trained and experienced in external turn (turning the child in the womb through external pressure) or a breech delivery (DGGG 2020, 40-44).

These five influencing factors are important to understand the complexity of the rising C-section rate in Germany. However, the most important aspects regarding why this rate is so alarming are the effects of C-sections for the child and the mother.

The WHO and the international healthcare community are recommending a C-section rate between 10% and 15% since 1985. The reason for that is that the use of C-sections in emergencies to prevent maternal and perinatal mortality is medically justified. Nevertheless, benefits for women or children who do not need this procedure are not proofed but the short and long term impacts of C-sections can affect the health of the children and women (WHO 2015a, 1).

In the statement of Caesarean section rates of the WHO is written: "Caesarean sections can cause significant and sometimes permanent complications, disability or death particularly in settings that lack the facilities and/or capacity to properly conduct safe surgery and treat surgical complications. Caesarean sections should ideally only be undertaken when medically necessary" (WHO 2015a, 1). The consequences for the women and the children who experienced a C-sections have to be recognised to create a critical understanding of the high rate of C-sections. It is important to consider the short and long-term consequences of C-sections compared to spontaneous deliveries.

In Germany, the operations and sewing technique, the regional anesthesia and the prevention of infections have developed, which is why the short-term risks of C-sections are lower than they have been 10 years ago. However, a C-section is still an operation which bears risks. The long-term risks can influence the health of the children in their childhood. Children who were born by C-section have a higher risk of developing asthma and obesity within their first five years of childhood (DGGG 2020, 33-34).

The long-term effects for the mother are different than for the children. The study of Keag, Norman und Stock (2018) point out, that there is a higher risk for women`s subsequent pregnancies if they´ve had a previous C-section. These women have a higher risk of having a placenta disorder, a placenta praevia, a placenta accreta and/or a placenta abruption. A C-section is always an emotional and psychological stress which is why

psychological support postpartum is relevant, especially if it was an emergency C-section. (Kaeg et al. 2018, 2-5). Even the impacts of C-sections for mother and child differentiate, they will affect both in a direct or indirect way.

The German Association of Gynaecology and Obstetrics is underlying the fact that more national and international studies are needed to analyse the long-term consequences of C-sections. They are emphasizing to raise awareness of the advantages and disadvantages of C-sections and their risks (DGGG 2020, 33-34). After a study of the Royal College of Obstetricians and Gynaecology more than 50% of all pregnant women wish to have more information about the risks of C-sections before birth (Thomas et al. 2000, 579). There are three main factors which are influencing the mother on the decision of the birth procedure, first it is the fear of birth, the pain and the recover process after birth, second, the information she received before birth and third her expectations towards the birth of her child. The information and the support of the medical staff are significant for the decision process of the birth procedure, because the women tend to rather adjust their decision on the opinion of the medical staff than on their own. Thereby the time pressure and the different level of medical knowledge between the women and the medical personnel plays a crucial role (DGGG 2020, 22-24). That is why, the DGGG is emphasising three decision-making models which lead to a stronger involvement of the women into this process. A right of a self-determined birth and the legal requirements in Germany lead to an involvement of the women. The first type is called informed consent, were advantages and disadvantages of the treatment method are presented and the woman can agree or disagree based on the information she got. The person wo explains the information decides about the scope of the information. The second type, informed choice, differs to the first one because the women gets presented additional information and treatment alternatives. The last and most inclusive form is the shared decision-making

process which has six steps. Firstly, the information will be shared with the woman, secondly, the form of involvement into the process will be discussed, then the different responsibilities of the woman, the midwife and the doctor will be defined, after that an extensive explanation about the information and alternatives will be provided and finally a common decision will be made. The guidelines of the DGGG are asking to implement the last form of the decision-making process because a missing inclusion while it is needed has negative medical implications (DGGG 2020, 21-22).

This process is also relevant for women who wish a Cesarean delivery on maternal request. The German and international average of CDMR is around 7%. In some countries this new form of delivery is gaining popularity. The DGGG promotes an in-depth analysis of the wish, because it is a multifaceted problem. On one side, the risks for mother and child have to be discussed, on the other side the women have a co- and self-determination right which has to be respected. A psychological support with a focus on fear for delivery can help to analyse this phenomenon. Comparing the impact of the birth procedure on the relationship of mother and child, the differences of CDMR and vaginal birth by primiparous women (first time mothers) get visible. Being asked after time periods of two days and after three month, the women who had a CDMR are reporting a better birth experience than the women with a vaginal birth. Concerning the proportion of breastfeeding women who had a vaginal birth being asked in the same time slots, their satisfaction is higher compared to women with a CDMR (93% to 79%). Through breastfeeding the bonding process gets supported and a close relationship of mother child results which is important for a healthy development of the child (DGGG 2020, 50-51). C-section and its ambivalent character as an important yet harming procedure is an example of physical obstetric violence and the process of medicalisation. Its common use,

understanding, wide distribution and justification shows that the impacts which are deepened in chapter 3.5 are not spread.

Episiotomy

Episiotomy is another example for direct violence within obstetric violence. Similar to C-section the episiotomy rate in Germany is higher than the recommended 10% from the WHO.

Generally speaking, an episiotomy is a "surgical enlargement of the vaginal orifice by an incision to the perineum during the last part of the second stage of labour or delivery" (Clesse et al. 2019, 760) and is one of the most common obstetrics operations (Zahn et al. 2006, 14). Numerous studies proved in the meantime that an episiotomy has hardly any advantages to a perineal tear. Especially the liberal and routine based use of episiotomy has disadvantages towards the restrictive (selective) use of it. The liberal use intensifies the risk for rear perineal tear, operative medical suture, tissue repair disorders, an anal incontinence, increased blood loss and postnatal pain. The only advantage is the reduced risk for an anterior perineal tear towards the urethra (Zahn et al. 2006, 15-16). The reason for the popularity of an episiotomy lies in history. In 1742 episiotomy was made for the first time and was described as an emergency procedure. Because of the risk of infection and the lack of anesthesia this surgery was used rarely. Around hundred years later episiotomy started to become an "appropriate elective response to some obstetric emergencies" (Clesse et al. 2019, 764). The recommendations of physician based on their own experiences did not have a big impact. The fear of the patients, the non-typical surgical interventions during birth, the unpredictability of consequential damages and perineal laceration in general, and lack of technology were some reasons for the cautious use of episiotomy as a routine. In the beginning of the next century, the practice of

episiotomies got more popular and some practitioners wanted to generalise this procedure whether as prophylactic measures or as emergency procedure to minimise the pain for the child and/or the effort of the mother. The hope was, to minimise the maternal and neonatal morbidity and mortality, because episiotomy is shortened the second stage of labour. Along with this development a change of the childbearing discourse happened. Birth was now seen as a pathological process which is situated in hospitals with preventive acts and under the control of obstetrics. The institutionalisation and medicalisation of birth went on and influenced the use of episiotomy during the 50s, 60s and 70s. Episiotomy turned into a routine procedure and became part of two thirds of births in highly developed countries. But in the beginning of the 80s the routine use of episiotomies was questioned because of the missing evidenced justification. After several studies the WHO and the international medical community proposed a restrictive use of episiotomies (Clesse et al. 2019, 760-771). In 1998 the frequency of episiotomies of all vaginal childbirth in Germany and in the USA was around 50-60%, in France around 38% and 28% in Great Britain. Already four years later Germany had a rate of 39% and 27% in 2010 (Zahn et al. 2006, 33). In 20% of all vaginal deliveries in Germany an episiotomy was made in 2015 (Heihoff-Klose 2018, 551). Most industrialised countries followed the trend of a reduction of episiotomy rates. Interesting to see is that China and India did not follow this decreasing trend which is why industrialisation and medicalisation are seen as the main reasons for an increase of episiotomy. Socio-culutral factors like the medicalised perception, the interest in innovativeness and efficiency of medicine and the general representation of the female body in the medical field and the society also played a role in the liberal practice of episiotomy (Clesse et al. 2019, 760-771).

Typical relative indicators which justify an episiotomy are a missing delivery progress, a child with macrosomia or genetic circumstances of the mother or child which

increase the risk of a severe perineal trauma. However, the preferences of the patient and its consent have to be respected in any case (Zahn et al. 2006, 15-16).

Episiotomy is a form of direct violence because it is a procedure which is used in one fifth of all childbirths, even though it is not needed in every birth and should not be used prophylactically since it has no major advantages over a perineal tear. Furthermore, a routine use does not have any advantages compared to a restrictive one, but rather disadvantages. Even though the use is decreasing it is often happening without the consent of the mother. The (over)use without the medical justification is the basis of the violence.

3.2.3.2.   Psychological Violence

The second part of direct violence is called direct psychological which is in contrast to direct physical violence hard to detect. It bases on words, gestures, symbols, pictures, deprivations of necessities of life or "[…] force [of] others into subjugation through intimidation and fear" (Imbusch 2003, 23). This violence is not outwardly visible and it works undetected. Its effects differ between the victims, because they react in an individual way through their defence and coping mechanism (Imbusch 2003, 23). Psychological violence includes the ignorance of the rights and wishes of the women, the abuse of power through the use of insults, threats or extortion, the laughing or shouting at the birthing mother, the lack of information or the spread of misinformation and the leaving alone with questions and concern. Further, when the patient is put under pressure through threats and insults to give their consent for the interventions it is understood as violence (Mundlos 2015, 36-49).

The impact of psychological violence is visible in the postpartum period and has long-term impacts which is why it is deepened in the chapter about impacts of obstetric violence (3.5).

3.2.4. Structural Violence

Structural violence stands besides direct violence and cultural violence and completed Galtung's concept of violence in 1969. It is characterised by the structure which enables violence to occur. People get hurt through direct and structural violence, however structural violence cannot be tracked back to one actor, group or an organisation. It is built into a structure and causes unequal power distribution and thus unequal life chances (Galtung 1969, 170-171).

That is why the identification of mistreatment and the perpetrator is not enough to end obstetric violence. The roots are embedded in history and structures of maternity care. This structure enables, tolerates or encourages to act in a violent way (Kukura 2018, 765-766). Galtung argues that structural violence is the breeding ground for further direct violence and is more deadly and deconstructive than direct violence in the long run (Galtung 1969, 184). He states further that there is a difference in how people are affected by structural violence depending on time and space. For Galtung there is no doubt that a violent structure has an impact on the mind and the spirit of the human body (Galtung 2013a, 37-38).

In the case of obstetric violence Kukura (2018) is discussing general structural patterns which create fertile breeding for violence. The economic pressure is the first concern and it includes the political and economic arrangements which govern maternity care services, the local distribution of maternity care and the shift from small to large medical facilities on the macro level. This influences women on how and where they receive maternity care. Furthermore, the diagnosis-related group (DRG), which are case related fees are relevant to analyse in order to identify financial incentives for specific treatments. Besides inductions and caesarean there are other cost-efficient incentives which can lead to unnecessary procedures. It is important to mention that clinical

practices do not directly imply an intentional immoral behaviour of the medical staff, it can also be led by a subconscious behaviour without knowing the impact of the economic aspects on their decision-making process. Behaviour can also base on habits which gets handed down to younger or new colleagues (Kukura 2018, 765-769).

These economic and political influencing factors are in the long run resulting in a lack of medical staff, a high workload, economic based financial incentives and limited time for the patients. The structural underfunding of obstetrics and the high insurance sum for midwives' base on a misogynist health policy (Mundlos 2015, 187).

Another concern of Kukura is the process of medicalisation, which brought more technology and interventions, and promoted efficiency and maximisation. A change of the maternity discourse took place within this process and with it a change towards a pathological view on childbirth with the excessive monitoring and treatment procedures came along. These new medical norms are visible in the high rates of interventions. Through the process of medicalisation, structures have changed and the patient-medical staff relationship has been influenced. The process of giving birth becomes more depersonalised because through the dependency on technology, more patients can be monitored remotely at the same time. Furthermore, the power dynamics have changed since the medical staff has the control and the knowledge about the medical technology on whose basis the interventions are decided. Another point is the fact that a woman can be seen as irresponsible, when she questions a new norm which includes more interventions (Kukura 2018, 769-770).

The legal protection of the physicians is the third concern which creates a fertile breeding for violence. Possible obstetric incidents and their legal consequences can be avoided through medical preventive measures. On basis of the German jurisdiction, the physicians are protected if they exhausted every medical possibility (Mundlos 2017, 316).

These explanations illustrate that structural violence is embedded into a system which cannot be tracked back to one specific actor. Especially the unequal power structure and the machinery of social oppression between different 'actors' like government with the medical political guidelines, clinic administration, medical staff among each other and to women, live partners and society, are getting revealed by analysing the structural pattern behind obstetric violence. There are regional differences between the impacts of these structures which can be explained by the different political guidelines, legal basis and legislations which themselves grew out of cultural and historical structures. One example is that in the different countries the extent of the education of midwives, their area of responsibility and the legal framework are different which creates diverse structures of power relations between the actors. For instance, the administration of medications for an induction of labour is depending on the legal framework and thus on the person in charge. This differs among countries and results in the fact that the dependency and hierarchy between doctors and midwifes are varying.

Another importance is that besides the diverse actors the different macro frames are also influencing the analysis of structural violence. After obstetric violence is an example for feminist issues, gender violence, maternity rights, human rights violation and more the different structures vary from each other.

The following chapter discusses the part of cultural violence within obstetric violence and concludes the analysis of the three types of violence.

3.2.5. Cultural Violence

The third type of the violence triangle of Galtung is called cultural violence, which "[…] highlights the ways in which the acts of direct and structural violence are legitimized, internalized, and thus rendered acceptable in society" (Galtung 2013a, 38).

The birth culture of Germany is characterised by a positive understanding of medical intervention during birth and by the medical progress in general. This positive view of medical interventions supports the idea, that too few interventions can only bring harm for the mother and child, whereas too many interventions cannot harm anybody, because interventions are bringing benefits. The process of changing birth medicine influenced the birth culture and took possession of the female body whereas the women are denied of their birth rights and their ability to give birth (Mundlos 2015, 49).

Obstetric violence is a complex and intertwined setting, where the social and cultural dimensions are integrated. The dichotomy of victims (women, mothers) and victimiser (healthcare provider) is limiting an analysis which cannot meet the complexity of this phenomenon like discussed in the preceding subchapter. That is why a combination of cultural aspects and structural dimensions can fulfil this complexity (Sadler et al. 2016, 51)

The question is, which cultural aspects are influencing the childbirth in Germany? One aspect is the understanding of the ubiquitous socialisation which constantly surrounds the humanity and has to be observed to understand the violence and the power dynamics within this complex phenomenon. Within the socialisation, violent structures are reproducing themselves through hidden information and intensions, accepted norms and normalised actions and the dualism of perpetrator and victims (Sadler et al. 2016, 51). Furthermore, the working conditions of healthcare providers are another point which symbolises the low importance of them in the society, politics and economy. This can be seen as violence as well, because these conditions are also resulting in a secondary trauma, stress or burnouts by healthcare providers and affect their working motivation (Sadler et al. 2016, 51).

Also, that the knowledge of the midwives and obstetrics of a non-invasive birth procedure get lost. This phenomenon is visible through the increasing C-section rate due to anomalies of presentation such as breech presentation, twin births or by previous C-sections experience. Another element is, that the information about the operation of the C-sections do not include the impacts for the child. This presentation leads to the impression, that operative delivery is better than a vaginal birth but the opposite is the truth. Paediatricians and psychotherapist increasingly warn against short- and long-lasting impacts for children (Brock 2018, 163).

Furthermore, is the society`s perception on doctors and medical staff being white dressed gods/goddesses which creates a self-entered hierarchy between patient and doctor. The trust into the German medical care, into the knowledge, the experiences and the medically founded decision of the medical staff are forming the basis of this hierarchy which the patients enter on their own. This hierarchy creates dependencies and an unequal power relation, which can be seen as basis of violence (Douse 2004, 285-286). The trust into the healthcare provider is a problematic aspect, because the patient is in a weak and vulnerable position and is looking for help which makes mistreatment during childbirth and enforcement of (personal) interests and norms which is hard to grab (Kukura 2018, 727). Another cultural aspect which looks at the patient`s (women) side, is the understanding of pain, especially the pain during childbirth. The understanding of pain is characterised by culture. It can be experienced in different ways, firstly in the concrete pain experience and secondly in the handling of it (Schmiedebach 2002, 419). This experience and the subjective intensity of pain are correlating with psychological factors like attitude and motivation as well as with the cultural background (Kizilhan 2016, 346). In the medical understanding, pain is the excitation of the pain receptors and the complex sensory of sensations. It is a biological alarm signal with a protecting function. This kind

of definition does not include chronical or psychological elements of pain. Cultural studies are rather focussing on the cultural differences of the handling of pain and the unconscious judgement structures and processes which define pain as something unbearable or not unbearable. There is not a general definition of pain which can cover the diverse anthroposophical, cultural and scientific aspects of this phenomenon (Schmiedebach 2002, 419).

The history shows, that the understanding of pain has changed over the centuries in the occidential world. In the 17ᵗʰ century René Descartes created the basis for the modern understanding of pain, when he separated consciousness as the realising subject from the object. In other words, it was the separation of heart and soul. Consequently, pain is a pure bodily process which can be seen as a reflect. The pain in the body releases a defence and protection reaction which arrives through nerve tracts to the soul. The separation of body and soul continued in the following centuries and turned pain into a purely bodily phenomenon. The clear understanding of pain as a bodily disorder lead to a pure medical reaction with anaesthesia or operation starting in the 19ᵗʰ century. The cultural and religious handling of pain which was embedded in the society till then, lost their meaning and was only used in relation to psychological pain. During that time the medical pain relief during childbirth concentrated on pathological births. The change came around 1900 when the twilight sleep was discovered. The women who experienced this trance-like state, which works on basis of morphine and scopolamine, were awake and able to cooperate but could not remember anything afterwards. Despite the side effects this procedure was considered modern and progressive. The image of weak women during that time supported the development of the twilight sleep, which provoked that this method was not only used for women with weak nerves but for the modern women. The idea was, that women can deal better and more effectively with the increased

demands of their nerve system during labour. Since the 1920s, this view has changed and the witness of the childbirth is considered to have an essential impact on the rise of the maternal feelings and the relationship between mother and child (Schmiedebach 2002, 421).

Today a negative view of pain and suffer is dominating and does not fit to a self-confident woman and her birth experience. The fear of the pain during birth goes along with the fear of loss of control of the own body and fear of not being able to handle the pain. However, it is important to acknowledge that women have the strength to accept and handle the pain. The birth pain does not have to be controlled by medicine. The women can confront it with her own strength, even it is not smooth pain, it has an immense power as well as the birthing woman (Ahorner and Schadauer 2008, 173-174).

This means, that the understanding of pain within society influences how women deal with it and confront those responsible. The self-determination is supporting the women to decide in which way they deal with the pain whether by means of (epidural) anaesthesia or without it. The violent aspect comes into play, when the women has the impression that there are only two options delivering – with pain or due to the aid of anaesthesia without it.

Also, the understanding that childbirth has to hurt is widely spread, which supports the prior arguments. However, the contraction pain is a signal for the start of the birth and should not been seen as an enemy (Ahorner and Schadauer 2008, 88).

Cultural violence is embedded into social structures which changes over time and influences the birth culture of each country. On the one hand, it depends of how women are seeing birth, evaluating their capacity to give birth and dealing with pain and strength. On the other hand, the society is influencing the birth culture, how birth is seen, understood and discussed within the society and how the women and their capacity is

evaluated. It is cultural violence if women are pushed into a role and position even if they do not agree or do not know about alternatives. It is also cultural violence if for example the use of C-sections and episiotomy are legitimized and accepted within the society even though they do not have any scientific justification.

After analysing obstetric violence with the help of Galtung's triangle of violence, the gender aspect and especially the power relations within obstetric violence will be discussed by using the feminist perspective, before having a look at the Children Rights' Conventions and the German law.

3.3. Gender and Obstetric Violence

Feminist discourses are seeing the patriarchal structured society as the driving factor which affects women's bodies and births though the values of the medical system (Lee and Kirkman 2008, 462). The constructed character of the patriarchal structure is according to the feminist important for the understanding (Diniz and d'Oliveir 1998, 36), whereas the midwifery discourses focus more on the paternalistic and hierarchical power structure within the medicine. Even though hierarchical power structures within the medicine are also part of the patriarchal discourse, the feminist discourse includes further the domination, oppression and exploitation of women within the society and the medical system. Feminism claims that the medicine keeps women's bodies under control (Lee and Kirkman 2008, 448-462). In general, the gendered power function and knowledge within the society supporting the masculine profession of medicine (Lee and Kirkman 2008, 462). Even though two third of all medical graduates are male, 84,2% of all gynaecologist and obstetrics in Germany in 2017 were female with an increasing tendency. Reasons for this feminisation within the last 20 years are poor career perspectives, the low income within this field, the working conditions and a dominating female image of gynaecology

within the society. The men are having a dominant role in the group of older and head physicians which can be explained with the development, that not many male gynaecologists / obstetrics follow and the existing ones are getting older (Riepen 2017, 24-34). This could be seen as a positive development for a deconstruction of the patriarchal structures within the medicine, however this development follows centuries of a male leading field. A breaking up of old structures needs a cultural change, which is why an understanding of various factors of obstetric violence like medicalisation, hierarchy, regionality, policies or gender have to be taken into consideration.

Nevertheless, the bodies of women are controlled, controlled by a medicine which is trusting machines, losing the connection to its patients and believing that doctors are the experts in childbirth. The medicalisation strengthens this understanding of childbirth and supports the transformation from a natural to a medicalised, controlled and monitored childbirth, where obstetricians are surgeons. But a childbirth is not a medical event (Lee and Kirkman 2008, 458-460).

The first historical step of the medicalisation was the final determination of the male body as benchmark for the human body, whereas the female body and especially the pregnancy and birth are abnormal, substandard and even pathological. Childbirth is defined as a pathological condition which has to be managed by technology and high-tech medicine. Besides the pathological understanding it seems like that the women are represented as headless and cut into little bits – an induction of labour here, an episiotomy there (Lee and Kirkman 2008, 458-459). The "diagnosis of pregnancy", the "pregnancy symptoms" and the understanding of a return to a "normal state after birth" are underlying the common linguistic understanding of a "male normalisation" medicine (Sadler et al. 2016, 51). This reinforces the patriarchally power structures, the oppression and domination of women's bodies and childbirth (Lee and Kirkman 2008, 461). A result of

this patriarchal pattern is that birthing women losing their trust into their body and experiences. Sometimes a consent of the medical staff is wanted to officially start the delivery or the pushing (Shabot 2015, 236). Women in labour are not more fragile, vulnerable or less powerful (Diniz and d'Oliveir 1998, 36), but they are on the bottom of the hierarchy in the hospital and the apparent choice of a self-determined birth is an illusion within patriarchal structures in hospitals (Lee and Kirkman 2008, 458). However, nothing justifies the obstetric violence against women as well as the current routines and practices (Diniz and d'Oliveir 1998, 4).

Obstetric violence is a feminist issue, it is directed at women and it is part of a patriarchal oppression which affects women, the child and another medical staff (Shabot 2015, 233). It includes gender inequalities and violence (Sadler et al. 2016, 49), and bases more on structural violence than on behaviour, which means, that the medical staff does not have to be aware of its violent actions and act as an "unconscious perpetrator of an existing violent structure" or is as well self-affected of it (Shabot, 2015, 233). Through its structural character, it systematic violates women's and children's rights (Diniz and d'Oliveir 1998, 40). Further, the reproduction and reinforcement of violence by different actors from women to families up to professionals and decision-makers can stabilise a gender narrative and obstetric violence. With this understanding of obstetric violence, it has the potential to address the multiple forms of violence and the hidden structure (Sadler et al. 2016, 48-52).

The feminist lens is helping to bring the focus back to the women, because the constructed power relations within obstetric violence are affecting women directly. Obstetric violence exists world-wide and the international and the national legal frames are influencing its extent, which is why the Human Rights, the Convention of the Right

of the Child and the German laws regarding childbirth will be discussed in the following chapter.

3.4. Rights and Obstetric Violence

In 2014 the World Health Organisation has started to address the issue between the mistreatment during childbirth and the human rights violations. Many forms of mistreatment were unaddressed or insufficiently studied under the international human right laws (Khosla and Zampas 2016, 131). The call for greater action became louder. The WHO stated that "every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful healthcare throughout pregnancy and childbirth, as well as the right to be free from violence" (WHO 2015b, 1). The human rights are indivisible and interconnected which explains, why one form of mistreatment implicates different human rights and the other way around.

The forms of violence through the use of force, physical restraint, physical examinations and procedures, neglect and abandonment, lack of supportive care, harsh language, discrimination based on sex, gender, race, religion or socio-economic status, lack of informed consent, lack of resources like staffing shortages and the lack of privacy, are all falling under various relevant human rights. The main eight rights which are violated are: Right to be free from violence, right to be free from torture and other ill-treatment, right to non-discrimination, right to health, right to privacy (including physical and mental integrity), right to be free from practices that harm women and girls and right to information (Khosla and Zampas 2016, 139). This means that the analysed forms of violence – direct, structural and cultural – are all falling under these human rights.

It remains to be seen if the human rights are already applying for the unborn child, but they certainly are the rights of the mother. During pregnancy and childbirth, the

mother has a special protective role which involves a particular responsibility regarding the unborn child (Zimmermann 2017, 77). On the legal perspective, the Convention on the Rights of the Child (CRC) gives a good starting point. It was adopted in 1989 by the General Assembly of the UN and little by little ratified by nearly every state. The Convention reflects the ambition of the protection of the human rights under international law and is the result of many traditional and former international child protection movements. Already in 1913, at the first international children rights congress in Brussel, international regulations were discussed and in 1924 the Declaration of the Rights of the Child was adopted from the League of Nations in Geneva. After many years of consulting, the General Assembly adopted the Resolution 1386 (XIV) - Declaration of the Rights of the Child - in November 1959 (BMFSFJ 2014, 33-35).

Regarding the situation in the delivery room the question is, if the CRC applies to the unborn child during childbirth and thus giving the child a voice. Therefore, article one of the CRC has to be fulfilled. Article one says: "For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier" (UNHCHR 1989). This article does not mention the unborn child which means that it seems to be left outside of the convention. This has been one of the controversial points since the beginning, because some questioned the general wording, others criticised the not binding agreement and demand a mandatorily right of protection of the unborn child besides national laws (UNICEF 2014, 74). The first compromise wording reads: "every human being", which gives every state the space for interpretation. However, for some delegation this was not enough which is why in the second compromise the ninth sentences of the preamble of the conventions got extended by the phrase "appropriate legal protection, before as well as after birth" (UNHCHR 1989). This phrase was copied from the Resolution from 1959

of the Declaration of the Rights of the Child (UNICEF 2014, 74) and is not supposed to influence the full scope of article 1 of the CRC. Because in the end, this convention is not a binding obligation to protect unborn life (BMFSFJ 2014, 44), it is a guideline.

After there is space of interpretation for every country, it is relevant to see how Germany interprets article 1 and the phrase in the preamble. According to the family ministry and the German Civil Code (BGB) the necessity of an "appropriate legal protection, before as well as after birth" (UNHCHR 1989) is accepted by different legal provisions. A human has in fact full legal capacity only after completion of birth (§ 1BGB). If the child is however already capable to inherit, it is defined as 'different' and protected against prenatal damage and can claim its subsistence if its mother dies (BMFSFJ 2014, 44). These rights still do not talk about childbirth in particular, which is interesting, because the German Penal Code (StGB) says that in the prevailing opinion with the start of the dilation contractions the child is defined as a human (Zimmermann 2017, 50). The unborn is a human because of the mother, which gives her a special role and responsibility. Because of this special bond the doctor needs the consent of the mother to administer medication. However, there can be a moment during childbirth when the mother is incapable to give her consent because of severe pain. This temporarily incapacity is common for medical intervention like an operation and anaesthetic, however, during childbirth this moment is not possible to identify in time. This harbours the risk of interventions without consent. Besides the question of consent there can be a conflict of interests between mother and child. After mother and child are seen as equal with the same rights, both interests have to be respected from the medical personnel. This means for the doctor that there is a criminal liability due to bodily injury or homicide. The doctor is caught between two stools. He/She has to respect the will and the consent of the mother as well as the interests of the child. Especially in the moment when the

mother is temporarily incapable to give her consent, this dichotomy can have legal consequences for both the doctor and the mother. Normally, the doctor obtains the consent before birth if there is an indication for possible medical interventions. In the German law, there is no principle which makes a medical information about all possibilities obligatory before birth. The justification is that the mother should not be bothered by the information, the risks and the decisions before birth. However, by a rate of over 30% C-section, a higher rate of episiotomy and the common use of PDA, an extensive consulting before birth about these interventions is necessary. Consequently, the mother is denied by her right of free decision in a calm moment, and she has to give her consent in a situation which is drawn by stress, pain and pressure. A consent which is given under pain can be legally attacked and questioned, therefore a presentation of all typical obstetrical intervention, possible risks and alternatives before birth is necessary to ensure the rights and obligations of the mother and doctor (Zimmermann 2017, 53-71). These legal gaps and structural information deficits result into the fact that the mother experiences the birth as an incapacitation.

Although the family ministry said, Germany gives a "legal protection before as well as after birth" (UNHCHR 1989), it is insufficient for the time during birth, when through insufficient information the will and the consent of the mother are ignored or overridden. The point is, when the mother is not protected, the child is it even less, and this affects the relationship between mother and child. Besides the understanding and the analysis of the different levels and structures of obstetric violence, the influence of gender and legal protection as well as the impacts on the different actors are relevant to analyse. This is why the next chapter addresses this topic and focuses on specific perspectives.

3.5. Impacts of Obstetric Violence

Experiences of violence are diverse which is why this chapter includes different perspectives of the impact of obstetric violence. Firstly, the short and long- time impact of obstetric violence on individuals who are present during birth – the mother, the child, the life partner and the medical staff – will be discussed. Secondly, the impact on German birth culture will follow. To understand the profound impacts of obstetric violence, the prior analysis of direct, structural and cultural violence during childbirth is important to keep in mind.

Experiences of violence and thus obstetric violence are influencing the society in the long run, have an impact on physical and psychological states as well as on relationships between parents and /or to their child.

The first perspective taken into account by this paper, is the woman, the mother, who stands in the centre of obstetric violence. Her emotional and psychological reactions on obstetric violence range from grief and anger to serious illness and life changing decisions. Women with these experiences are traumatised (Mundlos 2015, 169).

Around 20% of all childbirths are experienced as traumatic by the mothers, 10% of the mothers are showing a traumatic stress reaction in the first weeks postpartum and 3% of them develop a posttraumatic stress disorder (PTSD) in the first weeks postpartum. There is still not as much data regarding the psychological impact of traumatic birth experiences as there is for physical pain (Weidner et al. 2018, 189).

Nevertheless, mental suffering has a long-term impact for the mother and her relationships. Sleep disturbance (Insomnia) is for example a maintaining factor of 44% of the women (Weidner et al. 2018, 189). Further effects can be fear of failure, doubts and a reduced coping mechanism which supports the development of (postpartum) depressions and PTSDs (Mundlos 2015, 172-176; Weidner et al. 2018, 190). The fear of

birth represents, besides the connection to higher demand of Cesarean delivery on maternal request or (epidural) anaesthesia as discussed above, an important risk factor for traumatic birth experience for women whose preferred birth procedure differed from the real one. The violation of the personal integrity thereby bears the risk (Weidner et al. 2018, 190). There are two types of traumatisation, the primary one can be developed through real or subjective threat to the person itself or the child. Severe pain, fear or foetal problems like a striking CTG can lead to the feeling of helplessness, vulnerability and loss of control and to symptoms of an acute stress reaction. Additionally, if the preferred birth procedure differs because of surgical interventions, it can create the feeling of insufficiency and guilt. Especially secondary C-sections are a risk factor for the development of PTSD, because the decision is mostly made fast and under pressure after an unsatisfied birth process. On the one hand the woman has to give away her control which creates the feeling of helplessness and powerlessness, on the other hand she is worried about her child. She is in a conflict between the wish for a healthy child and the violation of her own body integrity (Ayers et al. 2006, 392; Weidner et al. 2018, 191-192).

There is also the risk of a secondary traumatisation, which means that women go through an update of a previous traumatic experience. This re-traumatisation is the result of an accumulation of stimuli or lived trigger, which can be intimated by touch/examinations, birth or examination positons which create a feeling of being at the mercy, presence of male obstetrics, spoken words like requests, pain because of the loss of control, shouting women from other rooms, bleedings, uncontrolled loss of urine and stool, smells and colours. Emotional numbness, dissociation, shame, aggression, panic attacks, flight impulse, strengthened pain intensity and a prolonged labour are symptoms which indicate a secondary traumatisation (Weidner et al. 2018, 191-192).

In summary, women who had a negative birth experience feel guilt and insufficiency which leads to a repression process. Not the medical birth process with justified medical interventions and the danger of mother and child are the crucial factors, but rather the subjective perception of the birth experience which has a decisive influence on the development of a postpartum PTSD. It is interesting that fear of birth, prenatal depression and general fear are mediated from the subjective birth experience, whereas prenatal PTSD Symptoms are an independent variable for postnatal PTSD symptoms (Weidner et al. 2018, 192; Simpson and Catling 2016, 4).

The current analysed psychological impacts showed that symptoms of an acute stress respond or of a PTSD can happen after a traumatic birth experience. During the postnatal time this experience will not be processed as a positive experience and combined with a proud feeling, but rather memorised in pictures of fear and threats which stay in mind or are repressed. This handling process bears a high risk of sleep disturbance, panic attacks or hyperarousal and in the worst case the newborn child will be defined as the cause of the trauma and thus ignored. It is not uncommon that depressive decompensations or other trauma consequential injuries appear. Out of these injuries, interactions and relationship disorders towards the child can develop. Mothers with a PTSD are less often breast feeding their children. Untreated mother-child-interactions and relationship disorders bear the risk that the child is developing a reactive attachment disorder (RAD), which is a precursor of lifelong physical and mental illnesses (Weidner et al. 2018, 193; Simpson and Catling 2016, 4).

A qualitative study of Ayers and scholars summarized the pain of the women as following:

“Women reported changes in physical wellbeing, mood and behaviour, social interaction, and fear of childbirth. Women reported negative effects on their

relationship with their partner including sexual dysfunction, disagreements, and blame for events of birth. The mother-baby bond was also seriously affected. Nearly all women reported initial feelings of rejection towards the baby but this changed over time. Long-term, women seemed to have either avoidant or anxious attachments with their child. It is concluded that childbirth-related PTSD can have severe and lasting effects on women and their relationships with their partner and children." (Ayers et al. 2006, 389)

Besides the psychological impacts, the mother can suffer from physical ones which are easier to recognise, because they are resulted through interventions during birth and will be noted in the record. Some physical effects can be hematomas at the costal arch or on the upper abdomen due to the Kristeller manoeuvre, wounds at the vagina through the episiotomy or perineal laceration which can be induced through the Kristeller manoeuvre or unphysiological birth positions, stitching wounds after episiotomies or perineal laceration, excessive bleeding or violations of uterine orifice (Mundlos 2015, 173). Women are felling terrible after their vagina has been mutilated, they do not have any sensation or lost their relation to their own sexual organ (Ayers et al. 2006, 389). These physical wounds are caused by diverse medical intervention against mother and child during birth which is why they are both affected. The mother and the child are in a constant interaction, prenatal, during birth and postnatal.

The biological impacts of birth procedures with many interventions for the child are well researched (Brock 2018, 162). These effects can base on physical violence and can include wounds, the KISS-Syndrome (functional restrictions of the upper cervical spine), plexus parese (the birth traumatic paralysis of the arm), bone fractures, damage of the central nervous system and more, which are all caused by C-sections, the Kristeller manoeuvre, micro blood-sampling and other interventions (Mundlos 2015, 173-174). Further physical risks which have been partially discussed within the scope of C-sections

are allergies, asthma, diabetes and adiposity. They can also imply short and long-lasting psychological impacts. The higher risk for allergies arises because the germs of the vaginal flora are missing. There are multidimensional connections and no guarantee that children of a C-section have asthma, diabetes and adiposity in combination with psychological disorders more often but more and more long time research is finding evidence for this correlation (Brock 2018, 162).

Furthermore, children can suffer from psychosomatic effects after a traumatic birth experience. Examples for these effects are stress-related colic, emerging breastfeeding problems, insatiable crying (screaming) babies (often represented), failure to thrive, an extreme need for closeness/intimacy to feel save and/or the opposite and reactive attachment disorder (Mundlos 2015, 172-176). Especially the current research on the psychological impacts of C-sections are not child-centred, because the real trauma is not the operation itself, it is the sudden loss of the archaic security (Hildebrandt et al. 2014, cited in Brock 2018, 162). There are children who compensate this experience, and mothers who have little pain and no traumatic memories. However, the voices of the women, paediatricians and psychologist who fight against this extensive use of C-sections are getting louder, because this birth procedure has a long-lasting impact. C-sections have a bearing on the children and their capacity of attention, their language development and personality (Teichmann 2013; Janus 2000, cited in Brock 2018, 163-164).

Depending on the type of C-section, the impact on the children varies. The primary C-sections is happening before the contractions starts without any noticeable announcement within less than four minutes. The children have to perform a big adaption process to the life outside the womb. It is a shock situation in which the children have to deal with the change of the metabolism. The moment of the C-section is earlier than the natural start, the lung is still immature and the systemic circulation is not activated, which

is why the adjustment process takes more energy and time. Scientist assume that these children can have the problem to be courageous and curious when they are older, because they fear the risk of being negatively surprised. The situation is different for the secondary C-section, which has contractions and an unplanned (emergency) situation preceding. The previous contractions are indeed helping that the adjustment process is easier for the child, however it is characterised by the maternal stress and fear, sometimes from the anaesthetised area and the emergency situation. The feeling of – I did not make it and I had to be saved – stays (Brock 2018, 165-166).

Besides the C-section, the induction of labour has a psychological impact on the child. The induction comes surprisingly for the child which is blindsided in this moment. These children are later in life often living withdrawal from social life, daydreamers, sensitive, slow and fearful. Normally the labour starts when the baby starts, which means the baby decides when it is ready (Thurmann 2018, 197).

The crucial aspect is that mother and child are in a constant exchange and interaction, which means that any obstetric violence affects the child both pre- and postnatal (Mundlos 2015, 172-176). The current state of research is that mental stress of the mother is prenatal influencing the stress regulation of the child, which means that prenatal experiences are influencing the stress management and the personal development of the child (Hochauf 2018, 86-87). In summary, if the bonding process is influenced through medical interventions, C-sections, fear, pain, separation or operation sequences, the interaction of mother and child is complicated and can lead to adjustment problems, breath-feeding problems and the other psychological effects which have been discussed. Consequently, the invasive maternity care has a psychological impact on mother and child and affects the further development of the child (Brock 2018, 175). This means that the

psychological process of pregnancy and birth has a transgenerational importance (Weidner et al. 2018, 193).

Besides all the impacts on mother and child, life partners cannot be excluded. By witnessing violence, they are also traumatised. An Australian study found out that around 5% of all life partners develop a postpartum depression after a traumatic birth experience. Reasons are that they witnessed violence which was directed against two loved people and felt helpless, powerless and guilty not being able to protect their partner and child. Some even feel themselves as an accomplice, because they were pushed to hold their partner or to talk them into an intervention. The process of these incidents is hard for the life partner because they tend to talk less about it (Mundlos 2015, 175).

Some midwifes are also traumatised and experience similar mental consequences as the women. They are witnessing violence and feel as accomplice where they have been pushed or obligated to act. The reactions are different, some break off their training, others turn their back on the clinical birth after their training and still others accept the actions as long as they are not practising it (Mundlos 2017, 314; Mundlos 2018, 76). A re-traumatisation can also happen, if midwifes are witnessing acts of violence which remind them on their own experiences with violence (Mundlos 2017, 312).

Through the medicalisation and the development in the last 30 years in Germany a vicious circle has been developed. The legal safeguarding protects the fear of having claims for damages. Physicians are on the safe side with a C-section, whereas complication are possible during a vaginal birth which have to be defended in court. There are some automatisms which feed this vicious circle (Renz-Polster 2018, 214).

If a woman had a previous C-section as her first birth, the second birth will usually also be a C-section, even if studies proved that this is not necessary and the new guidelines (DGGG 2020) request to try a vaginal birth before aiming for another planned birth.

Secondly, with the increasing rate of operational interventions and C-sections the knowledge and skills of the midwifery knowledge for vaginal birth without interventions is getting lost. Thirdly, the popular use of inductions of labour bears the risk to lead to a cascade of interventions. (Renz-Polster 208, 214) Fourthly, the length of childbirths has been shortened which is a result of time pressure and interventions. Hospitals, delivery rooms and birth houses are shut down because of profitability reasons (Mundlos 2018, 76). Fifthly, the commitment to security results in a tolerance of more interventions and C-sections and plays the long-term effects (physical and mental wise) down or does not include them into the assessment. This goes along with fears, uncertainty an inexperience of obstetricians and midwives regarding vaginal birth.

Concluding, the focus of the birth culture is not on the child and the mother anymore but rather on the efficiency of the childbirth. The midwifery is caught in established procedures of a medicalised world. The women deliver a baby but do not bear a baby, in their own rhythm, time and way (Albrecht-Engel 2018, 48-51).

3.6. Conclusion Dehumanisation of Childbirth in Germany

This chapter about dehumanisation of childbirth in Germany analysed the dehumanising structures before, during and after childbirth on the one hand and discussed how these structures impact mother, child and their relationship on the other hand.

This thesis` analysis starts with the process of medicalisation which changed the discourse of childbirth into an obstetrician and technical guided procedure with more intervention, in which the women are objects that have to be monitored by machines and influenced by medications. This change was the breeding ground for different forms of violence being normalised and embedded into daily structures and being led by economic, social and political arrangements. Each of the unnecessary intervention is in itself a sign

for a dehumanised structure. Scientific findings proof the harmful impact of these interventions, but the daily routine and normalised structures are allowing and demanding it.

Using the triangle of Galtung made it possible to show how these structures are acting independently but simultaneously influencing each other. Coming back to the explanation about the triangle of violence (Galtung 2013a, 46-58), the analysis shows that the cultural violence is lived, the structural violence is institutionalised and the direct violence is partly accepted in the obstetrics in Germany today. The remarks about the triangle showed furthermore that structural and cultural violence grew out of history and support direct violence. However, it is also a vicious circle in which the ongoing and normalised direct violence is confirming the structures and transmitting the culture. The differences in their time relation are also visible, for example, the C-sections are seen as individual events being experienced by one woman, structural violence like the economic and political pressure are variable and changing within time, and the culture is in a constant transformation like the understanding of gender has changed in the last years.

The dehumanised structures within childbirth are complex and deeply interwoven. One aspect can be the starting point and an effect at the same time making it a disentanglement and a transformation as well as a complex process. But, in general, obstetric violence has to become visible, free from taboos and discussed within the German society, politics and the hospitals, to break the silence which gives these harmful structures and practises their power. The status of normality has to be changed by naming it as violence and thus transforming it. The fact that only 6% of all births in German hospitals are happening without any interventions, has to shake the common understanding of childbirth and the positive image of medicalisation (Mundlos 2015,39).

However, the medicalisation per se should not be under general suspicion, but the harmful effects, the routines and the abusive use have to be changed. As long as childbirth is influenced by established androcentric procedure, patriarchal power structures which are supported by the medicalised treatment and a positive connotation of a constant medical surveillance by the society, the violence will be played down and the needs of the women will be invisible and disrespected.

This leads to the second focus of this chapter, the impact of these dehumanised structures. If the pregnancy and the obstetric care is dominated by and oriented on medical technology and medications and the mother and the child are seen as objects, the risk for traumatisation is high. Consequential, generations are growing up which have to process different traumatic experience (Brock 2018, 162-183). The physical and psychological consequences for the child of any intervention has to be respected, because the time before, during and after birth is a continuum with different developments and learning processes which are interwoven and depending on each other. The fundament of the basic feelings of security and trust are laid during this time. The birth is the moment, when the child leaves its protective armour and has to be welcomed in a loving way in order to allow a save postnatal bonding (ISPPM 2005,1).

The obstetric violence, the violence against women during childbirth, is a complex phenomenon which needs a multidimensional and -disciplinary approach to address and solve it, because every kind of violence during childbirth affects the women, their child, their bonding and thus has an impact on the society. Moreover, the respectful maternity care is a human right and has to be respected and implemented as guidelines in the medical institutions. The patriarchal structures which carry gender violence have to be deconstructed through respect, empathy and dialogue between patient and medical staff.

The next chapter will focus on possibilities to transform the dehumanised childbirth in Germany into a humanised one.

4. Peaceful Proposal Towards a Humanised Childbirth

As the previous chapters, have shown, the phenomenon of dehumanisation in childbirth is complex and multidimensional, which is why this proposal follows the example of the previous analysis using a wide angle and an interdisciplinary approach.

The goal of this proposal with a peace perspective is to discuss existing guidelines and ideas regarding humanisation of childbirth, to include peace concepts and propose further perspectives and tools to merge everything within a peaceful transformation process towards humanised childbirth in Germany.

The focus in this proposal will not be on one single actor who or action level which needs to take action in order to create the aforementioned transformation. It will include elements like personification, empathy and education, as well as diverse actors from politics (international and national), active groups and organisations, medical staff, (pregnant) women, society, and the research field. The approach is that a transformation which starts from different levels and directions can handle a complex and intertwined phenomenon. Some of these recommendations for action and change which will be presented are not new and have been published and edited over the last years from the different actors and authors. In the second part of this chapter, approaches of different scholars of peace studies will be presented to create knowledge of peace, care, conflict and conflict transformation as well as to build upon this knowledge to implement tools which support the process of transformation.

4.1. Transformation Towards a Humanised Childbirth

The goal of a humanised childbirth is to put women and children back into the centre of childbirth. Their needs, their fears and doubts, their hope and their strength have to be accompanied by midwifes and obstetricians, who work in harmony as equals and are oriented towards evidence-based service (Wagner 2001, 25). Women are human beings who are able to give birth, they are not "a container for making babies" (Wagner 2001, 25). Being in the centre means to control the own birth, to make decisions about what will happen to oneself, especially about medical interventions. "Humanized birth means maternity services which are based on good scientific evidence including evidence-based use of technology and drugs" (Wagner 2001, 25) which is the opposite of medicalised procedures. The idea of humanised birth is to assist birth, to work with the woman and support her own autonomic responses (Wagner 2001, 25-26). The idea is further to base the care in midwifery on the individual values and beliefs of the women and to "reinforce the principles of comprehensiveness, equity and accessibility" (Possati et al. 2017, 3-4), because it is not just a physical event, it is a biological, social and even spiritual for those who have a religious or spiritual belief. To perceive and acknowledge the diversity of the aspects that influence individual birth giving will lead to an interdisciplinary assistance (Marques et al. 2020, 6). This does not mean to override biology and to control it by using interventions like medications or surgical procedures (Wagner 2001, 25-26). Marsden Wagner highlights the paradox of medicalisation, humanisation and the attempt to "override biology at our peril" and gives the following example:

> „[..] if we stop using our bodies, they go wrong. It is 'modern' to get around in a car or public transport resulting in little walking much less running. Then science finds that our bodies need such exercise or we get cardiovascular problems. The post-modern idea is to go back to walking and running (jogging) and this is seen

as progressive, not retrogressive. By the same token, humanizing maternity services is not retrogressive but post-modern and progressive" (Wagner 2001, 27).

Consequently, humanising childbirth does not mean to go backwards, it means to take the best parts of both – the advantages of medicalised birth in the case of emergencies and the advantages of trusting in the ability of women to give birth and in the strength of humanised caring (Wagner 2001, 31). It is important to underline, that preventing obstetric violence does not necessarily equals improving respectful maternity care (Vogel et al. 2015, 672). It is comparable with the concept of positive and negative peace. Even when direct, structural and cultural violence during childbirth is absent, but equity and equality as well as a culture of peace are not lived within maternity care, it cannot be seen as positive peace (Galtung 2013b, 173-174). Therefore, an interdimensional approach with contribution of different disciplines, and actors of the international and national field are needed, especially to address structural violence in childbirth (Sadler et al. 2016, 52). Furthermore, a broad and inclusive approach is needed to "[…] ensure[s] the active participation of women, communities, healthcare providers, managers, health professional training, education and certification bodies, professional associations, governments and other health systems stakeholders in developing and implementing solutions" (Vogel et al. 2015, 673), laws and public policies (Jardim and Modena 2018, 10). It is certain that the process of "humanization is slow and full of challenges" (Possati et al. 2017, 5) and that there is not one single solution to achieve it. But it is the only way – a more humanised way.

4.2. Elements of a Transformation Towards a Humanised Childbirth

Within the transformation towards humanisation, basic elements within the diverse guidelines and ideas of the different actors are repetitive. This chapter focuses on eight aspects, the first six are the reaction of the six previous discussed reasons for dehumanisation from Haque and Waytz (2012) – individuation, agency reorientation, promoting similarity, personification and humanizing procedure, empathy, moral engagement (Haque and Waytz 2012, 180-182) and the last two aspects, education and evidence-based practise, are additional to conclude the prior.

Starting with individuation, which means that the identity of the patient is respected and that they will feel as individual and independent person which has the capability to make choices. It is the base line of the other seven aspects of the transformation towards humanisation.

The second aspect is to be an agent who can plan, act and intend. A patient turns into an agent if the medical staff give them the possibility to be an active partner who can make decisions and take responsibilities.

The third aspect is to promote similarity to create a relationship between patient and medical staff. These similarities can be created by promoting diversity within the medical staff, by emphasizing common humanity like vulnerability and by stopping labelling patients after their diseases.

The next three aspects are functional ones. Personification focuses on highlighting characteristics of the patient and distinguishing them from objects. This must not be confused with individuation which is similar but focuses on distinguishing one patient from the mass. Haque and Waytz are promoting to mention the name and one more information about the patient like profession or hobbies to personalize them. Personification is visualising the patients and their humanity.

The fifth aspect empathy is a complex element. It is a common understanding between medical staff, especially between doctors, that suppressing empathy is assisting them to solve high level complex therapeutic problems. However, it is also known that physicians and patients are benefitting from empathy. Haque and Waytz conclude this contradiction with the statement, that "both empathy and cognitive problem solving should be recognized as important in certain contexts but also equally detrimental in others" (Haque and Waytz 2012, 181).

The sixth aspect, moral engagement, goes along with empathy. It is important within the process of humanisation to decrease the psychological distance which can also be created by technical equipment (Haque and Waytz 2012, 180-182). Additional to these six aspects for a successful transformation of dehumanised childbirth are education, and evidence-based practices. Regarding the education, it is important to educate the medical staff further about the importance of humanization, the possible change in behaviour and action within the transformation (Possati et al. 2017, 5), the impact of dehumanised care on patients and on medical staff, and the gender violence related dimensions (Sadler et al. 2016, 53).

The last aspect which is repetitively mentioned within the different ideas on transforming dehumanised childbirth is the need of evidence-based practice. Normalised procedures have to be questioned and exchanged by scientific findings and practices. The evidence-based approach protects the patients from unnecessary interventions and the over- and underuse of medical technology (Possati et al. 2017, 4; Lalonde Pascali-Bonaro 2018, 9).

The understanding of these elements is relevant for discussing the guidelines of the different actors and the peace proposal. There are more elements existing, however these aforementioned eight ones can be seen as a general baseline for additionals.

4.3. Actors of Transformation

This list of actors is not aiming for completeness, due to being a complex and changing phenomenon with a net of different actors. All ideas for transformation and all changes that individual actors have to make would go beyond the scope of this thesis, which is why a selection of actors was made. Each subsection is representing a group of actors out of which individual actors and their ideas, guidelines and/or the necessary changes are discussed.

Besides the representatives of international and national politics and active groups/associations, the main actors of the medical staff are considered. Also, the changes which pregnant women have to make are mentioned. The last two groups are the general German society and researchers of the different fields.

4.3.1. International Political Actors

"Birth is political" (Wagner 2001, 35), which is why a deeper look into the political arena is relevant to transform obstetric violence. Dehumanised childbirth is a worldwide phenomenon which is why the international community is discussing and thematising it. Most relevant actors are the United Nations and the World Health Organisation which are guiding the discussion and the plan of change between the international political actors.

In the beginning of the discourse on childbirth humanisation the international concerns rather focused on mortality rate and the non-evidence-based interventions which result into direct violence (Sadler et al. 2016, 48) than on the deconstruction of the structural violence within the constructed patriarchal system.

Especially the deeper look into the development of the humanised approach, makes it clear that the action of the international community only started in 2015. The

general focus was on non-evidence-based medicalisation of birth and the violence which goes along, even though the concept of humanisation had already started to be discussed 30 years earlier in Latin America. However, the WHO published in 2015 the typology of different forms of mistreatment and declared them one year later as human rights violations. Since then is obstetric violence part of the global health governance agenda (Williams and Meier 2019, 9). The urgency to abolish this violence demands rather a deconstruction of the phenomenon which respects the interdisciplinary character, includes the structural violence within the society and recognises the different geographical and social contexts to promote and develop dialog and a respectful healthcare (Diniz and d'Oliveir 1998, 40; Lee and Kirkman 2008, 463). Since 2018, the studies of the reproductive healthcare community are focussing on obstetric violence, the understanding of the structural factors and its improvement on empirical data. The special rapporteur on violence against women (VAW) of the United Nations published in 2019 the report "A human-rights approach to mistreatment and violence against women during reproductive health services with a focus on childbirth and obstetric violence". This report finally defined obstetric violence as a form of VAW which violates human rights rather than solely a question of quality of maternity care (Williams and Meier 2019, 9).

The recommendations for states and stakeholders which the UN 2019 (Appendix 1) formulated base on this human-rights-based approach. It gives general recommendations for states as well as guidelines to ensure informed consent, to prevent obstetric violence, to provide accountability and to destroy discriminating laws and gender stereotypes.

The human-rights approach further opens up new possibilities to achieve multisectoral policies even though the risk is existent that these possibilities and solutions stay within the human rights community. Nevertheless, an effective transformation

towards humanised childbirth needs a multisectoral cooperation of global health and human rights level, which goes along the shared understanding of WHO and UN on obstetric violence. Through the policy recommendations this report strengthens these multisectoral cooperations and enables the implementation of international norms through national policies. This report is as well underlining that obstetric violence is violating a variety of human rights "which include the rights to health, privacy, freedom from discrimination, freedom from violence, and freedom from torture and other ill-treatment, among others" (Williams and Meier 2019, 10). Besides the policies and legal security guidelines which the national agencies can draw from this report, the indicators of obstetric violence can expand existing programs like the Sustainable Development Goals (SDGs) which in turn guide programs at national level (Williams and Meier 2019, 10-11).

A small excursion within the report about SDGs and obstetric violence shows, that there is not one specific SDG which thematise obstetric violence, rather various which discussing or touching parts of it.

Out of 17 goals, goal 3.2, aims for the decrease of the neonatal mortality rate to less than 12 deaths per 1000 live births by 2030. The second goal 3.8 pursues the access to qualitative, safe, effective and affordable health-care service, medicine and vaccines for all. These two sub-targets are the most relevant ones regarding respectful maternity care. Since gender-based violence can prevent that women receive healthcare, goal number five is relevant as well for a humanisation of childbirth. Fully termination of all forms of discrimination against girls and women and elimination of harmful practices are the first two sub-targets number 5.1 and 5.3 of the fifth SDG. Number 5.6 combines goal number three and five and demands to "ensure universal access to sexual and reproductive health care and reproductive rights […]" (United Nations 2015, 16-18). These goals offer

a baseline for a transformation, however, they are not discussing the quality of care or the structural elements of obstetric violence and are thus not focussing on the humanisation of maternity care.

To conclude this recommendation of the UN as a representative of the international politics, it has to be noted, that interdisciplinary collaborations and multisectoral policies are needed to implement the human rights approach comprehensively and eliminate obstetric violence (Williams and Meier 2019, 10).

As carved out above, international political actors provide recommendations which have to be translated into the national settings. In contrast to the beginning of the discussion, which left much room for interpretation, the UN Report of 2019 contains clear expectations towards the international community.

4.3.2. National Political Actors in Germany

The response on national requests of medical staff, patients, unions, society or international recommendations can differ from state to state or even governmental periods. Few topics regarding maternity care are dominating the discussion on shortcomings related to childbirth in Germany, for example the staff shortage in delivery rooms, the workload and the low wage of midwives. Issues like obstetric violence have in contrast not played an important role within national policies in the last years. The main actors of the national policy are the government and the different parties within the parliament. This chapter focuses on recently published reports, key issue papers and requests of the government and other government-related parties to select suitable strategies for the government to take up in response on current grievances in midwifery and especially to obstetric violence.

In 2017 the ministry of health published the national health objective 'health around childbirth' which was orientated on the salutogenetic and not on the risk-centred perspective. It defined pregnancy, birth and the postpartum period as a vital life period for mother, parents and children. In general, it is an agreement with different actors of the health care system who want to develop and improve the general health of the society (Altgeld and Kuhn 2017, 7).

These national health objectives were followed by a key issue paper which includes five actions, in the beginning of 2019. Out of the five actions, two have already been completely realised – a report 'on the current and future situation of the stationary care through midwives' and the academisation. The academisation, which turned the apprenticeship of midwifery into an academic study in 2020 was an EU target with an expiring deadline. The other three issues, the improvement of the compatibility of family and job of midwives, the securing of the supply of follow-up care during the postpartum period and the encouragement of the return of midwives to fulltime positions are still in the process of realisation (BMG 2019, 1-2)

The report 'on the current and future situation of the stationary care through midwives' in the delivery room in hospitals which was published by the government in 2019 is important to acknowledge when dealing with current grievances in childbirth, because due to being the newest publication on the named topic it takes into consideration current numbers and development within the supply through midwives commissioned by the government.

For this report, midwives, mothers and hospitals participated in a survey to find out what the structural problems within the maternity health care system are. In general, there is an increase in the birth rate as well as a small one in the rate of midwives working in hospitals. The work overload and staff shortages of midwives could not be

compensated through this natural increase of educated midwives. The shortages mostly occur in birth centres and maternity clinics in bigger cities, whereas in rural areas smaller birth centres are working below the average capacity. Over 57% of the hospitals have 18% permanent vacancies of their possible permanent posts, because of the unattractive high workload (Albrecht et al. 2019, 245-248).

The ratio of midwives and birthing women per shift is between 1:3 or more generally speaking. 28% of all shifts have a birth rate above average. In these shifts one 85% of the midwives have to accompany four or more women in labour and/or birth (Bündnis 90/Die Grünen 2020, 2). Especially the perinatal centres have proportionally often a ratio of 1:3 or more between midwives and women. 70% of the questioned midwives would like to have a 1:1 care to guarantee a high qualitative care. The reason for this disparity is that the workforce capacity of midwives is not fitting the current birth rate. This lack of midwives' bas on different aspects. First, only one third of the midwives work fulltime. For 75% of the questioned midwives who work in part-time reasoned their decision to so with the high workload, the amount of overtime hours, night and weekend shifts as well as the on-call duties. Second, the high amount of duties besides the core activity, like cleaning, administrative tasks, fetching and bringing service and replenishment of drugs are further reasons for the decision to work part-time. The third reason is that through the increasing requirement of documentation and vast amount of administrative tasks in the last years, which are time-consuming and not part of the core activity, the time for qualitative care decreased. The problem grows as the labour supply is increasing whereas the tendency of midwives to work fulltime or to increase their working time is decreasing. The already high number of working hours, the difficulties to reduce overtime, the general dissatisfaction with the working conditions are influencing the personnel situation. The recognition of the work of midwives and their

incomes are not balanced appropriately with their workload. Many midwives are criticising the missing time for qualitative care and the inappropriate pathologising and medicalisation of childbirth with invasive interventions. The result of this imbalance is that 40% of the midwives are thinking about a reduction of their working time or the end of their carrier as a midwife in a hospital (Albrecht et al. 2019, 245-248).

The question is how the ministry of health wants to change these structural problems of the working conditions of midwives. The report gives short-term and long-term solutions. The first actions should prevent the capacity shortage which goes along with supply problems. However, the heterogeneity of the maternity clinics makes a general solution difficult, which is why specific measures are important.

There are three solutions provided in the report. First, the fusions of different maternity clinics to compensate the high workload with extra staff. This solution can result in an increasing need to commute among midwives and even longer distances for the birthing mothers. It should be noted that many maternity clinics have already been closed in the rural areas in the last years and a regional supply has to be ensured (Albrecht et al. 2019, 249-254). Since 1991, 43% of all hospitals with maternity ward have been closed. There were 1186 hospitals with a maternity ward in 1991 and 672 in 2017. Especially the hospitals with maternity ward with less than 500 childbirth per year were closed down and between 2010 and 2017 (Albrecht et al. 2019, 77-84).

The second solution is the minimisation of duties beside the core activity of midwives by means of employing cleaning personnel and administrative assistants. With this discharge of midwives, the amount of time for a qualitative care and the satisfaction of women and midwife is increasing. The last solution is to create financial incentives, but because of a collective agreement a salary increase is not easy to implement, which is why the report is recommending the aforementioned indirect incentives through

assistance and discharge of the midwives. The academisation of midwifery (since 2020 the apprenticeship of midwifery turned into an academic study) was among other drivers initiated to reason an increase of the remuneration level, yet its outcome is still unsure (Albrecht et al. 2019, 249-254).

Knowing about the complexity of dehumanised childbirth and especially obstetric violence, the government's report and the subsequent measures do not cope its intricacy. The report discloses different grievances, especially the structural ones such as the shortage of staff, and offers appropriated actions. The opposition parties such as the green party (Alliance 90/The Greens) is expressing their demand for an extensive change of midwifery in a request to the government, because the implemented measures or plans are in their opinion not sufficient for a change.

The request of the green party with the title 'cultural change in midwifery – focusing on women and children' discusses the current situation and formulates 4 requests with 16 sub-requests and was published in the beginning of 2020 (Appendix 2). The main point of criticism is that the scope of action of the federal government is not used fully and the existing shortcomings are still there. Even if the federal government is not responsible for every measure because of the principle of subsidiarity, its scope of action and existing tools should be used completely to create a supportive environment for a change in midwifery. Three areas of action are mentioned. First, the improvement of quality in the obstetrics and the strengthen of the freedom of choice of birthplace. Second, the enhancement of the working conditions of the midwives and third, the promotion of health. This request underlines, that an inclusion of all actors at the local, regional and national level is necessary for a comprehensive reform of midwifery. In consequence, it considers different levels of actions, including diverse actors and touching upon structural and cultural aspects which are influencing the situation. The request includes further

obstetric violence and the need of qualitative and women centred care (Bündnis 90/Die Grünen 2020, 3-5).

The national health objectives, the key issue paper of the government, the report which was commissioned by the federal government and the request of the green party are focusing on different aspects. The latter meets the challenges of the complexity of obstetric violence in the most humanised way, by including the quality of care. The ministry of health focuses on structural aspects, especially on security of supply of health care. They consequently focus not only on structural aspects e.g. within childbirth, but also on other current topics like the current health care situation with regard to the Covid-19 pandemic.

The corona pandemic 2020 sets out the grievances in the healthcare sector in clear terms, which is why the cabinet decided on an improvement of healthcare provisions and nursing on the 23rd of September 2020. This cabinet decision comprises additional midwives for maternity clinics and a funding program over Euro 65 millions per year in the following three years. With this funding, about 600 additional midwives and 700 assistance job vacancies can be created (BMG 2020).

The cabinet decision does not include thoughts on the general quality of care in midwifery beyond emergency plans during the pandemic. The request of the green party criticises this handling of the working conditions of midwives and highlight the importance of midwives during the pandemic. In the beginning of the pandemic, midwives where not defined as system-relevant actors, and were thereupon forgotten by the distribution of protective clothing. Therefore, they could not or just without medical protective clothing look after the women in their postpartum period. This symbolises a non-inclusive health policy and administrative approach (Bündnis 90/Die Grünen 2020, 2).

The policies of the German Ministry of Health are not based on a human right based approach as recommended in the UN report on mistreatment and violence against women from 2019 which has been discussed above (UN 2019) which have been already discussed. However, there must be taken into consideration that national health objectives from 2017 promote the physiological birth (childbirth without or less interventions), strengthens the health of mother and child and understands health as a combination of physical health and subjective quality of life and well-being. These goals do base on a woman centred concept of care with three elements – choice, control and continuity – and the respect of personal decisions of the women and their social, emotional, physical, psychological, spiritual and cultural needs (Altgeld and Kuhn 2017, 37-42). These national health objectives are however just a rough guideline and would create more impact if included into the §20 section 3 of the fifth book of the social code to strengthen its effectiveness and to be able to finance measures through the prevention bill as the green party requests (Bündnis 90/Die Grünen 2020, 8).

The objectives from 2017, with their main goal of a physiological birth include three sub goals and recommendations for action:

1- To encourage a low-intervention birth and strengthen the health resources

    a. Further development and use of the women centred care

    b. Integrate this concept in trainings

    c. Provision of material of evidence-based interventions

    d. Guarantee initial contact and bonding between mother and child

2- To identify burdens, risks and special needs for special support and offers

    a. Adapted care in the respective stage

    b. Consideration of individual stress (after previous experience of violence)

    c. Trainings for all involved actors in childbirth

    d.   Integration of cultural aspects into the trainings

    e.   Provide material in different languages

3- To ensure, that the participating groups who are involved in childbirth are working constructively together and guarantee continuous care

    a.   A completed maternity record book

    b.   A guarantee of a functioning communication between the different actors

    c.   Establishment of further trainings and exchange of knowledge between different actors and regional groups

    d.   Cooperation between perinatal care and neonatology (Altgeld and Kuhn 2017, 42-45).

Before these objectives have not been integrated in the social code, the implementation and measurements cannot be financed by the federal government and provide only a guidance (Bündnis 90/Die Grünen 2020, 8).

Michael Abou-Dakn, head physician in a German hospital, says in his paper on necessary changes of the clinical obstetrics, that among further changes, higher financial resources regarding structural changes and improved personnel allocation can enable a better quality of health/maternity care with less fear for the women and less interventions. Creating opportunities for humanised birth will require additional measures though. He further thematises that the measures toward a qualitative care and humanised birth do not require a big financial budget. The current saving policy [of the German government] has a negative impact at the expense of women's health care. Interventions are a more lucrative business, than natural birth. A redistribution of financial resources towards a 1:1 care a humanisation of childbirth could be pushed, by decreasing financial incentives for interventions and using this money for humanised structures (Abou-Dakn 2018, 234-

237). Additionally, humanised childbirth reduces the amount of follow-up treatment and consequently saves the health insurance resources (Mundlos 2015, 187).

Besides the impacts of the national parliament and the approaches of the federal office for public health, the legal situation around childbirth is highly relevant for a comprehensive transformation towards humanised childbirth. As indicated in chapter 3.4, the legal situation of childbirth remains a complex issue on its own. However, some concluding ideas can be formulated.

The medical staff should inform each new woman on possible medical interventions, their risks and alternatives. This information should be given in a calm moment in an early stage of time to minimise the present issue of violence during birth. With this approach the mother has time to process and decide on measures taken along her will and consent. Second, this allows the mother to give her authority to her partner or a defined person in case of an emergency. An emergency is a moment when the mother is temporarily incapable of giving her consent. The decision-making authority must be defined clearly. These two opportunities generate more respect towards the will and the consent of the mother and provide the opportunity to the mother to protect herself and the child from physical violence. Even though the law of the German Penal Code (StGB) is theoretically protecting birth-giving women from violence, they should be sufficiently informed about their national and international rights and their role as active protector. To give the child a voice during its birth, the laws and guidelines have to take into consideration and base on the importance of the birth itself and on the impacts of every intervention of childbirth (Zimmermann 2017, 77).

Concluding this chapter of national political actors, it visualises the importance of these actors as part of the mosaic of transformation. The analysed governmental reports and requests do not provide fall short of providing concrete plans or timelines on

improving the current situation in the delivery rooms, staff shortage or humanising childbirth. Their decisive influence bases on the ability to create laws and allocate financial resources and systemic structures. A change of the austerity policy is necessary to abolish the staff shortage and the financial incentives which lead to an unappropriated use of interventions and a dehumanised care.

4.3.3. International and National Associations and Organisations

Associations and NGOs are another important part of the mosaic of actors. They are on the one hand independent from the governments and on the other hand part of the society. They have the role of an independent observer who creates guidelines which can be implemented through the governments. There are many international and national associations who work towards a humanisation of childbirth. Two of such organizations are introduced in the following to show the importance of non-governmental perspectives. The first one, the International Childbirth Initiative (ICI), is a result of an international alliance of many international organisations. The reason for this collaboration is, that it combines older guidelines and recommendations of the leading international organisation in this field and has developed the largest and complex measure towards a humanised childbirth.

The second observed NGO is a German national association called Mother Hood e.V. This regional focus is important to discuss which recommendations and guidelines in the German context are seen and discussed.

The International Childbirth Initiative (ICI) is a complex and multidimensional guide in 12 steps. It has a wide emphasis on rights and quality of care with explicit requirements and the inclusion of the newborn.

One influencing element of the ICI was the International MotherBaby Childbirth Initiative (IMBCI) of the International MotherBaby Childbrith Organization (IMBCO) with its 10 Steps to Optimal MotherBaby Maternity Service which was published in 2008. These steps base on a US initiative and were extended and adapted to use them on a global level. The other element is the FIGO Guidelines to Mother-Baby Friendly Birthing Facilities which was developed in a collaboration of the International Federation of Gynecology and Obstetrics (FIGO), the WHO, the International Confederation of Midwives (ICM), the International Pediatrics Association (IPA) and the White Ribbon Alliance (WRA) and published in 2014. The philosophical and ethical base for these guidelines grounded in the WRA charter Respectful Maternity Care: The Universal Rights of Childbearing Women.

Due to the common principles, criteria and steps of the IMBCO and FIGO Guidelines a fusion and the creation of a joint force was useful. Finally, the ICI: 12 Steps to Safe and Respectful Mother-Baby-Family Maternity Care resulted from this collaboration created. Compared to the former and included elements, guidelines and publications, the ICI combines more steps, a wider range of rights and a broader understanding of quality of care as well as recognition of the newborn as important key element (Lalonde and Pascali-Bonaro 2018, 2).

The ICI has a human right focus which concentrates on women and infants. It bases on the WRA charter on Respectful Maternity Care which "clarifies and clearly articulates the rights of women and newborns while receiving maternity care within a healthcare facility" (WRA 2020). This campaign with its clear standards was launched in 2011 (Schuiling 2016, 3). The ten rights and their explanation as well as their legal authority are listed in Appendix 3 to provide background information.

The quality of care is besides the rights' focus another crucial factor within the ICI (Lalonde and Pascali-Bonaro 2018, 2). The current understanding and definition of quality in health care as well as the implementation in health care systems guided the ideas of care for the ICI. Three leading publications regarding quality of maternity care as health issue influenced the ICI's vision (Lalonde and Pascali-Bonaro 2018, 3): First, the Blueprint for advancing High-Value Maternity Care through Physiologic Childbearing (Avery et al 2018), which shows the short- and long-term benefits of care for mother and newborn, second, the WHO – Standards for Improving Quality of Maternal and Newborn Care in Health Facilities which focus on the prevention of maternal and newborn mortality rate, and finally, the WHO – Standards Improving Quality of Care for Children and Young Adolescents in Health Facilities with its recognition of the special and different needs of children (Lalonde and Pascali-Bonaro 2018, 3).

Further, the ICI bases on the "concepts of culturally sensitive and culturally safe maternity services" (Lalonde and Pascali-Bonaro 2018, 4) and addresses four topics: "accessibility, community participation, person-centred respectful care, and cohesiveness among maternity services along the continuum of care" (Lalonde and Pascali-Bonaro 2018, 4). Another aspect of care regarded by the ICI is the promotion of the concept of cultural safety and, consequently, the shift from the traditional understanding of care (care regardless of differences) towards a perception of care that focus on the personal needs. This shift requires cultural awareness, reflection and acknowledgement of the impact of their actions from the healthcare providers. The basis of this value-based model of care is the partnership between provider and user. The needs and expectations of the care recipient and the desired health outcome are the key drivers of the decision-making measures. The various care models have similar aims but differ in their type of recipient

of care, for example women, newborns, clients or family are defined as single recipients. The ICI defined MotherBaby-Family as one unit and one care recipient (Lalonde and Pascali-Bonaro 2018, 4). This unit stands in the centre of care. This idea of one unit came from the Canadian Family-Centred Maternity and Newborn Care: National Guidelines (Government of Canada 2017). The MotherBaby-Family Maternity Care Model, is integrated into the ICI and has some characteristics. It considers the first two years of a child as the most important ones in which parents and caregiver lay the fundament for a healthy life. Pregnancy, labour, and birth are defined as a physiological process which changes life and benefits from the work and philosophy of the midwives. The third characteristic of the ICI is the importance of multi-disciplinary teamwork and education with skills in communication, collaboration, and consultation. The care must be individualised, supportive and value-based as a partnership between MotherBaby-Family and healthcare provider. The healthcare provider should listen to the needs of the mother and her family and communicate in a culturally, sensitive, and understandable way to them. The pregnant woman, her family and the healthcare provider are deciding in a collaborative process whereby the woman is the final decision-maker. Another important characteristic is current and evidence-based knowledge as basis for education, the policy and practice. The last points of the "concepts of culturally sensitive and culturally safe maternity services" is, that mothers and babies should stay together whenever possible.

The foundation of the 12 steps of the ICI are the MotherBaby-Family maternity care model, its characteristics, and the ICI principles (Lalonde and Pascali-Bonaro 2018, 5-6).

The seven ICI principles are:

- "Advocating rights and access to care
- Ensuring respectful maternity care

- Protecting the MotherBaby-Family triad
- Promoting wellness, preventing illness and complications, and ensuring timely emergency referral and care
- Supporting women's autonomy and choices to facilitate a positive birthing experience
- Providing a healthy and positive birthing environment: the responsibilities of caregiver and health system
- Using an evidence-based approach to maternal health services based on the MotherBaby-Family Model of Care" (Lalonde and Pascali-Bonaro 2018, 7-9).

They are the product of the merger and the different visions and principles of the former initiatives. All principles with their subsections and explanations are listed in Appendix 4.

The core element of the ICI are the 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care. These steps enable women who receive care to have a positive birth experience and feel psychological and physical safe. Through evidence-based practise the risk of violence is minimised, and the normal physiology of labour and birth is supported. Furthermore, the safe maternity care is guided by the needs of the MotherBaby-Family unit. Respectful maternity care is characterized by inclusive, non-discriminating and accessible as well as affordable care and leads to compassion, privacy and dignity for the MoterBaby-Family unit. These steps are useable in every setting and can be implemented one after the other or completely, from bottom-up or top-down. Disregarding whether individuals, groups, facilities, or regional/national governments plan to implement these steps, the acceptance and the understanding of the guideline must be established among the respective community, health professionals, and representatives. For an implementation of these 12 steps the local needs must determine this implementation. The community must be engaged, the access to education and

trainings must be permitted and the support through national and/or regional experts must be available. The 12 steps are measurable and have indicators which allow monitoring and evaluations and which provide comprehensive information of each step (Lalonde and Pascali-Bonaro 2018, 10-20). The implementation "should be conducted positively, with the intention of supporting improvement, and not as a blaming and shaming process" (Lalonde and Pascali-Bonaro 2018, 20).

The discussion of each step would be to extensive, but the full and unabridged versions of these steps and their indicators are listed in Appendix 5. It gives an overview of the extensive and comprehensive information of these steps (Lalonde and Pascali-Bonaro 2018, 10-19).

In general, it has to be said, that these 12 steps are representing a comprehensive transformation towards a humanised childbirth and maternity care.

The German Mother Hood e.V. Association is committed to give women and children a carefree and supportive time during pregnancy, labour, birth and postpartum. The national Mother Hood e.V. initiative stands up for the right of a stress-free and healthy pregnancy, a save and self-determined birth and a healthy growing up of children in their first year. This association is with 40 regional groups and over 100 active participants the biggest association regarding safe childbirth in Germany and was founded in 2015. Besides its ten-point plan which was published in 2019, there are additional measures on local, regional and national level.

For example, representatives of Mother Hood e.V. are collaborating on the new S3 Guidelines[1] regarding vaginal childbirth which will be published by the end of the year 2020 (Mother Hood e.V. 2020). The goal of this S3 guideline is the provision of steps for a standardized evaluation of evidence-based interventions in childbirth on the delivery date. Besides participating in developing these guidelines, the Mother Hood e.V. association organises roundtables, working groups, conferences, discussions, presentations, publishes articles and comments in newspaper and journals, and is active on social media (Mother Hood e.V. 2020).

The above mentioned ten-point plan represents recommendations and claims from a German association towards the German healthcare policy and presents different approaches of solutions.

The reasons for the ten-point plan are provide solutions to known lacks of childbirth care e.g. the shortfall of staff allocation, the longer distances to birth clinics, the overcrowded delivery rooms, the 1:3 distribution of midwife and women, routine interventions which are often experienced as violence, and the lack of midwives for the care during pregnancy and postpartum period. The ten-point-plan's motto is: An investment in midwifery is an investment into a healthy society (Kliemt and Desery 2019, 1).

In contrast to the guidelines of other actors this ten-point plan is discussed below, because it reflects the German reaction to the prevailing situation.

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[1] S-guidelines are developed and classified in different levels, whereby S3 guidelines have the highest qualitative methodology of development. Whereas S1 guidelines are an informal consent of the medical society and only recommendations for actions, are S3 guidelines the result of a systematic scientific research of different studies, their methodological strength and clinical relevance. The goal is to formulate a uniformly advice, backed up with scientific knowledge. S3 guidelines are evidence- and consent based guidelines (IQWiG, 2020).

The first point is the needs-based salary. The reason is, that birth is not plannable. Care which is orientated on the individual needs of the woman and her child requires more time which must be compensated. The general intension of midwifery is the support and care of the physiological birth. However, the individual care and high administrative costs in the current situation are not considered. This results in insufficient care, economical pressure and leads to unnecessary interventions which can entail physical and psychological harm. Besides the midwives, the women and the quality of care, the hospitals are as well affected by this situation, and over 60% of them cannot cover their costs which results in closures of birth centres and delivery rooms. Mother Hood e.V. proposes a payment system for the midwifery work which is independent of the existing fee-per-case system.

The second point is the distribution of midwives in delivery rooms. A 1:1 service and support of midwife and women is the safest way of childbirth. Different studies are proving, that a continuous 1:1 care during birth, minimises the use of PDAs, episiotomies, operative births and results in less premature deliveries. The predominant distribution key of midwives is from 1986 and does not allow a re-calculation based on scientific and current circumstances. The distribution and allocation of midwives in Germany need to be re-calculated. Additional quality improvements can be made through earmarked funds for trainings and educations.

The third point is the security of care nearby. Birth needs acute care which includes emergency care, which is why care should be located nearby. In the last years, nearly 200 birth clinics/ facility got closed. Longer driving times bear the risk of emergencies or pathological progression. Also, women who admitted to hospital in an early stage of labour, experience often more interventions and complications. This early

hospital admission influences the already tensed situation regarding spatial and staff capacities.

The gathering of data regarding birth defects is the fourth point. To formulate reliable statements about the quality of midwifery, birth defects need to be gathered in clinical setting and evaluated on a case-by-case basis. There are no meaningful data about birth defects like the type of defect, the risk factors and arising damages. The absolute number of birth defects in Germany is unknown. There is no information about defects which has been caused by obstetrical staff within the delivery room. Till now there are just numbers for freelance midwives, which are stable on a low level with 20-30 birth defects per year. As long as more than 98% of all childbirths are happening in hospitals, an evaluation of birth defects is necessary. The collection of case-by-case data is important to start a structural and individual cause analysis.

The fifth point goes hand in hand with the last one, the insurance premiums. The reason is, that childbirth and midwifery are an essential component of the continuance of the society. The responsibility of obstetrics and the risks of birth damages should not only be managed by obstetricians and midwives. The problems are high and rising annual liability insurances which results in a financing problem for obstetricians and midwives. Data on birth defects could make a macrosocial solution which is independent from the market.

The sixth point goes back to the third SDG, the reduction of the maternity and neonatal mortality rate. The sixth point demands a correct collection of information on the maternity mortality rate. Only three out of sixteen regions follow the WHO guidelines and collect all cases of maternity mortality related to childbirth. The requirement says, to include deaths during the whole period of pregnancy, childbirth, postpartum till and one year after birth. Right now, only the number of maternal deaths during the hospital stay

is collected. If the mother changes the medical department or the hospital she will not be considered in the maternity mortality statistic.

The cross-sectoral cooperation is the seventh point in the plan. During the whole period of pregnancy up to one year after birth, women visit different medical health professionals. The coalition agreement of the current government says, that the treatment procedure has to be orientated on the needs of the patient. However, there are problems regarding the cross-sectoral cooperation, for example in the cooperation of clinical and non-clinic obstetrics, the paediatric care and the early psychological support. All professional groups who are involved in obstetrics have to work hand in hand like it is defined in the national health objective 'health around childbirth'.

The evidence-based obstetrics were already mentioned in most of the guidelines which have been discussed above, which is why it is not surprising to find it as well in this ten-point plan under point eight. The main reasons are, that the C-section rate and the unnecessary use of interventions in childbirth have to decrease as well as that the routine interventions and process need to be reviewed and questioned. The goal is that obstetrics acts are conducted according to evidence-based guidelines and in line with the security of mother and child. For this approach, scientific studies are necessary which are transferable to the German health system. Mother Hood e.V. is seeing potential in different points of research, for example in personal costs and distribution, data evaluation of additional and subsequent costs because of interventions during birth, frequency of obstetric violence, the medial presentation of childbirth and others. The diversity of these research ideas shows the complexity of this phenomenon.

The ninth point requests to strengthen women's, childrens' and patient's rights. Like discussed in the previous chapters obstetric violence is a breach of the human rights, the women rights. Through the implementation of the ten points of this plan the structural

violence will be reduced. Further, trainings and education in trauma-sensitive psychological support and supervisions are necessary to implement in the education of midwifery and gynaecologists.

The tenth point is the promotion of prevention measures and health competence. Parents need good and evidence-based information about the physiological processes of pregnancy and birth, possible interventions and risks as well as about their rights. Information are the basis for a self-determined decision-making process regarding the own health. Health competence around birth has to become a central concern of the health policy. The education work needs to be comprehensive, neutral, evidence-based and without fear, and have to inform about pregnancy, birth, breastfeeding and parenting. Furthermore, children should be educated in a positive view of health as well as birth.

The general aim is, to reach a sustainable and future-orientated health policy which lead to a better obstetrical care. This aim needs a comprehensive cooperation of different ministries, institutions, and organisations as well as the implementation of the national health objectives 'health around childbirth' as a legal and binding guideline (Kliemt and Desery 2019, 1-15).

The guidelines and plans of the international and national associations show, that both have their priority themes and objectives. The ICI focuses on the quality and the respectful maternity care, defines the MotherBaby-Family unit, has a human rights perspective as one basic element and proposes the 12 steps to all international and national levels. The Mother Hood e.V. in contrast focuses on more structural elements in the German context. The ten-points plan is designed for the grievances around childbirth in Germany. Similarities illustrate and underlines the global scope of this phenomenon with its regional characteristics.

After looking at the different institutions and their guidelines, the medical staff, pregnant women and the growing research field are analysed in their role as active actors within this transformation towards a humanised childbirth.

4.3.4. Medical Staff – Obstetrician and Midwives

The medical staff in the maternity ward in a hospital includes in general obstetricians, midwives, nurses, anaesthetist among others (Marques et al. 2020, 3), but the focus will be like in the whole thesis on obstetricians and midwives.

Obstetricians and midwives have an interesting position because, they are sitting between two chairs, one the one hand they are influenced by the conditions of healthcare policy, resource management of hospitals and their rules, on the other hand they have an impact on the experiences women make during their stay in the maternity ward and special during childbirth. By seeing the medical staff as an active actor, the question of their capacity to change their habits towards a humanised childbirth arises. How much can they change their habits within the system through training and education and how much has the system to change?

Adequate working conditions and the offer of trainings are relevant by influencing the working environment. These offer bases on human and material resources of the healthcare and hospital policy and their allocation of resources (Misago et al. 2001, 69; Busch et al. 2019, 471). The healthcare authorities are also obligated to provide evidence-based and unbiased information to medical staff as well as to women to justify medical interventions, decisions and behaviour (Sadler et al. 2016, 52).

Leaving the question of the quantity of trainings aside and focusing on the quality and content, many scholars repeat themselves by saying, that healthcare provider need trainings on psychological preparation (Busch et al. 2019, 471), knowledge about sexual

and reproduction rights of women, gender topics, humanisation (Jardim and Modena 2018, 9), sensitisation of violence, trauma prevention (Mundlos 2015, 183) and more. These trainings and education shall change the quality of care towards humanised childbirth, which goes along with the eight elements of humanised care of Haque and Waytz (2012) discussed in the previous chapter. Healthcare providers have to give the women a voice by listening to their questions, fears, doubts, desires and complaints (Possati et al. 2017, 5), to communicate in an accessible language (Marques et al. 2020, 9), to treat them and their individuality, humanity and dignity with respect and to include and respect their decision-making process. If women know about and understand their medical conditions and treatment they are receiving, they will feel respected and "being seen as an equal partner" (Busch et al. 2019, 470-471). A lack of connection with the women can be caused by exhaustion and being overworked (Marques et al. 2020,8). The relationship, the bond between medical staff, and especially midwives, and women is important for the quality of care. A holistic approach which understands the women and their caregivers as a whole is necessary and requires to consider care for caregiver as an important aspect. On the one hand, psychological support and the promotion of self-care skills (Busch et al. 2019, 4468-471) are needed, on the other hand a change of the hierarchical structures and the related dependences, power relations and pressure are important to create a more equal working environment (Sen et al. 2018, 15). A humanised care must start from different levels and angles like explained in the ICI steps (see 4.3.2), which means that the healthcare policy, the healthcare authorities, hospitals and medical staff have to take responsibility.

Through an evaluating system and collection and documentation of transparent data regarding interventions rates the quality of care could be made public and give the women the power to choose the hospital/ institution they prefer (Mundlos 2015, 190).

As always a complex phenomenon is not to be answered with a simple answer. On the one hand, healthcare providers have to change their habits and need further input to support their change and on the other hand, there are changes to the system necessary which need to be carried out.

4.3.5. Pregnant Women

Pregnant women are an active and relevant actor within this transformation towards a humanised childbirth. The main factor is, to "promote the active participation and decision-making of women in all aspects of their own care" (Misago et al. 2001, 69). This participation requires two things, first the involvement of the pregnant women into the decision-making process by the medical staff and second, the active interest of the pregnant women to inform themselves about their rights and possibilities in advance. The lack of knowledge of the women bears the risk, that they put themselves into a passive and depending position. This creates a hierarchy between medical staff and women. Based on the current grievances, the structural problems and the appearing violence it is even more important that women get informed and inform themselves, which enables them not to accept procedures and treatments without questioning them. If not expressing doubts, desires or their pain women experience violence without knowing or acknowledge it (Jardim and Modena 2018, 2). For this empowerment, women need evidence-based information about obstetric interventions, applicable regulations, standards and rights according WHO, UN and national recommendations/ laws (Jardim and Modena 2018, 9; Mundlos 2015, 180).

Besides the need of information, women should formulate their individual birth plan to reflect individually on their wishes, fears and doubts. If a woman knows what she wants and does not want she puts herself into an active position. For women who have

experienced a traumatic birth, the need of psychological support is big. It is proven that the rate of depression is lower, if women received psychological support afterwards (Weidner et al. 2018, 192-195).

4.3.6. Research Field

The existing research about the dehumanisation of medicine and childbirth is discussing causes, functions, and its effect, as well as the power structures between medical staff and patient/women (Haque and Waytz 2012, 183). The interdisciplinary character of this phenomenon raises new questions and the need of further research. Especially the need for evidence-based research regarding interventions and their effects is getting louder, because unnecessary interventions are affecting the quality of care during pregnancy, childbirth and postpartum and the relationship between mother and child (Sadler et al. 2016, 48; Schuiling 2016, 3). Further, research on obstetric violence worldwide, its definition, measurability and impact on women's health is important and necessary. As well as the effectiveness of interventions in various contexts need to be investigated and defined in guidelines for governments and healthcare providers (WHO 2014, 2). After the awareness and knowledge about obstetric violence and the need of humanisation grows as well as the information of maternity rights, obstetric interventions and their risks are public, further lacks of research and unanswered questions arise (Jardim and Modena 2018, 9).

This research field will grow with increasing interest, interdisciplinary and arising questions and will include more approaches and different contexts in the upcoming years. The research on specific detailed question will rise as well in addition to interdisciplinarity. Both developments are important to create a comprehensive understanding of this phenomenon.

The previous subchapters have shown first, the elements which are needed to create humanised childbirth, second, the different actors with their guidelines and ideas of change, and third, the different levels of action which are relevant for a transformation. Now, various concepts of peace studies will be discussed to strengthen the interdisciplinary perspective.

4.4. Peace Perspectives, Concepts and Tools

This subchapter combines various concepts of peace, conflict and conflict transformation from different scholars with tools which support a peaceful transformation towards a humanised childbirth. The goal is to focus on peaceful initiatives with nonviolence and creative approaches.

This peace perspective uses tools of peace education – Nonviolent Communication of Marshall Rosenberg (2015) and Peace Circle of Kay Pranis (2005) – and lays them over various peace approaches – imperfect peace of Francisco Muñoz (2010), Ethic of care of McLellan (2014), peacebuilding of John Paul Lederach (2003) and conflict transformation and *provention* of Paco Cascón Soriano (2001).

Like Cabezudo and Haavelsrud say "[i]t is necessary to define peace in order to discuss the content of peace education" (Cabezudo and Haavelsrud 2013, 3). This proposal starts by drawing a picture of peace by means of different scholars which frame this idea of transformation towards a humanised childbirth. Thereby will the general comprehension of peace base on las paces / many peaces of Vicent Martínez Guzmán and Wolfgang Dietrich. Peace is as diverse as the humanity and can be understood in many ways. Peace and with it, peace culture, is "a structure as well as a process" (Cabezudo and Haavelsrud 2013, 5). This culture is built by structures of peace. These structures base on values of peace which enhance and promote interactions between units. These

units can be individuals or groups up to international organisations. This peace process is happening by strengthening the peace values (Cabezudo and Haavelsrud 2013, 5) and the positive relation between these units in love, harmony and togetherness (Galtung 2011, 3). It is always "in process" and "unfinished" because it is understood as an imperfect road (Muñoz 2010, 1-2). The concept of imperfect peace of Francisco Muñoz supports the idea of a process of peace and enables with this understanding the inclusion of all peaces, no matter their size, level of interaction or their relationships (Muñoz 2010, 1). Furthermore, through the recognition of positive as well as negative peace new perspectives can be generated. Imperfect peace is the process between the positive and the negative peace, but also something transcendental. However, "imperfect peace is more than just the sum of all these peaces: it is a practical and theoretical tool that enables us to recognize, promote, and interrelate them" (Muñoz 2010, 1). This approach removes the dualism of good and bad, enables the recognition of the complexity of peace with all components, like values and experiences, and allows imperfection in being and doing. Imperfect peace is an understanding of peace and an instrument at the same time, which "provide[s] an intermediary path between maximalist utopianism and conservative conformism" (Muñoz 2010, 1-2).

This means that peace and with it, peace culture, is a complex structure, which consists out of various peaces and bases on values and includes their interrelations.

According to Betty Reardon the two essentials of culture of peace are care and hope. She underlines, that a culture of peace is a culture of caring. Thereby, caring is a capacity which can be developed from everyone (Reardon 2001, 85).

The process of caring, supports the development of two relevant skills for the creation of a peace culture, "skills for the peaceful transformation of conflicts, and civic and social commitment skills" (Comins Mingol 2009, 460).

This brings us to the ethics of care, which is elementary for midwifery and childbirth. Jennifer MacLellan (2014) talks about the caring dilemma in midwifery, and the tensions which result out of it. The dilemma is to balance the needs of the women and the demands of the institution (see 4.3.4). This balancing act affects midwives emotional and professionally and can lead to burnout (MacLellan 2014, 805; Newnham and Kirkham 2019, 3). When expectations of women are not met because of this tension, maternity care is described as dehumanised care. Over time, midwifery had to succumb to the norms and values of the dominating discourse of medicine. Consequently, midwifery became institutionalised and technologized with increasing technical interventions and the turn away from the traditional/natural birth. "This reflects an attitude of control, treating all births according to standardised timelines while ignoring the rhythms of labour unique to each woman" (MacLellan 2014, 805). With this process the basic elements of caring like relationships are sacrificed for an institutional and technical guided model of care. "The importance of the woman's perception of her birth experience cannot be underestimated" (MacLellan 2014, 804). As described above, these dehumanised experiences can impact the relationship of mother and child negatively. Fear could however be minimised through supportive relationship during childbirth, after it is a social event which depends on social processes and is based on relationships. McLellan proposed to introduce ethics of care and especially the partnership approach of care into midwifery care (MacLellan 2014, 805; Newnham and Kirkham 2019, 7). A relationship between midwife and woman creates a space in which midwives can meet the expectations of the women and their own ideas of responsibility (MacLellan 2014, 805). This ethic which bases on relationship and responsibility goes beyond a principle-based ethic which is ascribed to institution-centred care (Newnham and Kirkham 2019, 2).

Newnham and Kirkham built upon the ideas of MacLellan and say that the relationship between midwife and woman is essential for a humanised childbirth. If hospital policies or cultural practices are placed above the respect for the needs of the women, it can be described as unethical. The rhythm of the hospital influences the policies and practices and propel women through the current institutionalised system. The goal is, to keep them safe. Safety of the women is the crux of the matter, which makes it easier to get one's consent and conduct interventions, if the woman feels protected by the medical staff. This effects in women "going with the flow' of the institution rather than with their birthing bodies" (Newnham and Kirkham 2019, 3). Women will rather not ask for options which have not been presented to them which gives the medical staff and the institutions a great deal of power to present their favourite birth options. Thereby the general setting of power is unequal, because the more vulnerable woman is facing medicine power, institutional power and professional power (Newnham and Kirkham 2019, 7).

Additional to the question of power, the symbolism of safety is playing a role and is thereby a good example of cultural violence. Within this discourse, a safe birth is represented in a medical setting rather than in a non-institutional one. Practises which support a physiological birth fall short within the explained options and do not represent the symbolism of safety. The underlying point is that routine medical procedures of obstetric birth base "in a lack of trust in women's bodies to birth" (Newnham and Kirkham 2019, 3). Safety plays also a role within the tension between the needs of women and medical staff. Medical staff who follow institutional requirements, not because of moral duty but rather because it is their professional safeguard, are pushed to overcome their personal idea of woman-centred care and responsibility first, because their actions are only insured if they have followed the policy, which forces them to put themselves

and the institution above the woman. This tension influences the care relationship between women and medical staff (Newnham and Kirkham 2019, 8).

One thing is certain, the medical staff "often provide woman-centred care to the best of their ability – up to the point where they bump up against institutional requirements" (Newnham and Kirkham 2019, 8). Newnham, Kirkham and MacLellan are positive that a turn towards care ethics and the recognition of trusted relationships have the potential for humanising childbirth. The motto is clear, care takes time (Newnham and Kirkham 2019, 8).

Subsequently to addressing the understanding of peace, as an imperfect and unfinished process which builds the basis of culture of peace and the relevance of care as a peace value, the understanding of conflict and its transformation is being regarded in the following. All of the explanations are considered within the context of a transformation towards a humanised childbirth.

With the help of John Paul Lederach and his understanding of conflict, conflict transformation, peacebuilding, and the capacities of moral imagination the picture of a change will be drawn.

The basis is the understanding of conflict and transformation, "conflict is normal in human relationships, and conflict is a motor of change" (Lederach 2003, 5) and "transformation provides a clear and important vision because it brings into focus the horizon towards which we journey – the building of healthy relationships and communities, locally and globally. This goal requires real change in our current ways of relating" (Lederach 2003, 5). Conflict transformation as Lederach understands it, is more than a set of techniques, it is a way of seeing and looking at a conflict and realising, that there are different layers (current situation, underlying context and conceptual frame) which have to be included in the transformation. The metaphor of conflict transformation

which Lederachs gives is a person on a journey with a head, a heart, hands and legs which are all needed to complete the journey. The journey represents the recognition "that conflict is a normal and continuous dynamic within human relationships" (Lederach 2003, 15). Starting with the head, which represents the conceptual view of the conflict and the coordination of the attitudes and perceptions of possible responds, it also stands for a proactive attitude which sees the potential of conflict to be the catalyst for growth. The heart is the centre of emotions and intuitions and it is simultaneously the starting and the returning point. Within conflict transformation it represents the centre of human relationships and the web of connections within the large context. Furthermore, is the heart the life-giving element which keeps us alive. In conflict situations, this correlates with the view, that conflicts are natural and offer new opportunities to change and understand ourselves. Conflict is the motor of change. Coming to the limbs, the hands are responsible for touching, feeling and shaping and representing the development of change to create something positive out of negative and difficult settings, to be constructive rather than destructive and to cultivate capacities to change. The legs and feet are the connection to reality. Conflict transformation is only working if it responses to the needs and challenges of the real life. It sees peace not as a static and finial stage, but rather as a "continuously evolving and developing quality of relationship" (Lederach 2003, 20). The quality of relationships, which are constantly changing, adapting and evolving, is the root of peace (Lederach 2003, 14-22).

Besides this conceptual understanding of conflict transformation, certain capacities are necessary to develop. By means of the concept of moral imagination and its four elements of John Paul Lederach (2005), the picture of conflict transformation will be completed. The goal is to understand how moral imagination gives an opportunity to create a space for relationship, curiosity, creativity and risk and to find peace.

The leading question of Lederachs' book 'Moral Imagination' is "how do we transcend the cycles of violence that bewitch our human community while still living in them?". Lederach's approach is to "generate, mobilize, and build the moral imagination" (Lederach 2005, 5) to understand what the destructive relationships created and how they can be changed through the exploration of creativity. Mainly moral imagination "develops a capacity to perceive things beyond", emphasises the need of creativity and has the ability of transcendence. It gives birth to something which does not exists yet, which breaks down destructive pattern and cycles through imagining and generating constructed responses. The goal is not to find 'the single' solution, it rather "push[s] us toward understanding the nature of turning points and how destructive patterns are transcended" (Lederach 2005, 29). Lederach argues, that moral imagination arises while first imagining ourselves in relationships, second accepting complexity, third believing in creativity and lastly accepting the inherent risk. These are the four elements, capacities which are needed for a transformation within the peacebuilding process (Lederach 2005, 4-33).

Starting with relationship, it is important to understand, that everything is interconnected. To imagine oneself in a web of relationships including the enemies and its interdependency is the core of this element. Further, the self-recognition of being a part of the web and thus part of the structures everyone in this web is subjected to, is a crucial point. On one side stands being part of this web and on the other side, one's acts affecting it. Peacebuilding is requiring this understanding of relationship (Lederach 2005, 34-35).

The second element the paradoxical curiosity respects complexity and rejects dualism or either-or categories of the reality. Especially in violent settings are dualistic perspectives like – wrong/right, violator/liberator or bad/good – popular. Within this

concept, paradox means to find the truth beyond the initially perceived and the curiosity, that it is beyond accepted meanings (Lederach 2005, 35-36). Curiosity means to be open-minded towards ourselves and others, those we fear (Lederach 2016). "Paradoxical curiosity seeks something beyond what is visible, something that holds apparently contradictory and even violently opposed social energies together" (Lederach 2005, 36). By seeing complexity as a friend, new angles and opportunities are becoming visible and support the transformation. The basis of paradoxical curiosity is as well imagination (Lederach 2005, 35-37).

Creativity is the third element to rise moral imagination and makes it possible to move beyond the existing state and to reach unexpected areas. Creativity is always within our potential to reframe (Lederach 2016). The space which is needed to emerge creativity has to be open for the spirit, belief and ability of change through creativity. The idea about change leads to questions about what is possible in the world and prepare the space to create something new (Lederach 2005, 38-39).

The last element is "the willingness to take a risk" (Lederach 2005, 39) and to enter a new unknown area where no guarantee of success or safety exists. While violence is known, peace and risk are a mystery, but precisely this risk is needed for the journey of peacebuilding. It is important to explore the wide range of violence because that enables to reach new areas through imagination (Lederach 2005, 39). To take the risk to reach out to people who are on the other side, social courage is needed, but this courage means to have the ability to face the others and our own community, to communicate that this not the best version of how we could be. This means to have the courage to re-humanise the situation of conflict (Lederach 2016).

The peacebuilding process needs "the capacity of the actors to imagine themselves in relationship, a willingness to embrace complexity and not frame their challenge as a

dualistic polarity, acts of enormous creativity, and a willingness to risk" (Lederach 2005, 40).

Lederachs' approach of conflict, conflict transformation and peacebuilding, the ideas of imperfect peace of Francisco Muñoz, and the perception of culture of peace and ethic of care of McLellan, Comins Mingol and Newnham and Kirkham are creating the important theoretical fundament of this transformation. These ideas and understandings of peace and conflict need to put into praxis by means of peace education. Especially the ideas of transformation and *provention* of Paco Cascón Soriano are relevant.

Paco Cascón Soriano (2001) describes in his work 'Education in and for conflict' the role of peace education in conflict transformation and especially in *proventing* and preventing conflict through education. As well as Lederach understands Cascón Soriano conflict as something positive and sees the opportunity for a social change in it. Furthermore, the understanding of conflict as a process resemble one another to the other discussed approaches. The origin of conflicts lies in the needs, irrelevant if economic, ideological or biological, which is defined as the first stage of this process. If the needs become antagonistic, the process enters the second stage, the problem arises and other elements like mistrust, misunderstanding or fear can be mixed into it. Continuing and not resolving the problem, it enters the third stage and violence arises. Mostly at that point it is seen and identified as conflict. In this stage, it is hard to resolve the conflict in a non-violent and creative way, but it is still possible to do so. The difficulty is, that in that moment the supportive conditions of resolving it, like time, detachment and tranquillity are not existing. Consequently, the capacity to react in a non-violent way, to analyse, ask or think about it in a calm way and to look for alternatives is low. When a conflict reached that stage, it is difficult to reach a peaceful solution (Cascón Soriano 2001, 2-6). "Just as conflict is a process that may take some time to develop, its resolution, as previously

defined, must also be seen as a process and not one discrete action that will do away with all the problems" (Cascón Soriano 2001, 6). The idea of Paco Cascón Soriano is, to create space in which tools can be prepared and people be trained for dealing and resolving conflicts in a creative and satisfying way, that if the last stage is reached, it is possible to respond in a positive way. An educational environment is needed to learn how to analysise in a calm, dispassionate and leisurely way and to evolve creative ideas of resolving the conflict. "The main task of education for conflict will be learning to step back, to analyse the conflict and to respond in a constructive way" (Cascón Soriano 2001, 10), because the reflexive respond (action/reaction) does not support the non-violent manner. Education for peace is mainly working simultaneously on three levels: *provention*, analysis and negotiation and nonviolent action. Whereby non-violent means to fight for the personal rights while respecting the opponent.

The crucial point of Cascón Sorianos' approach is the idea of *provention*. This describes a process of pre-crisis interventions which lead to detailed explanations of the situation and the different dimensions, awareness of the necessary structural changes and the promotion of a supportive environment which foster cooperation. The interventions happening in an early stage and do not wait for the second or third stage of conflict. The different between *provention* and prevention which is customary used, is the understanding of conflict. Prevention describes the need to interact before the situation turns into a crisis and has a negative connotation. The goal is to avoid the conflict, to not let the inside out or observe the root causes. In contrast to *provention* which defines conflict as something positive, inseparable from human interactions and as an opportunity for growth. In the context of war or armed conflict, the term of prevention is still legitimated.

Provention requires a set of skills and strategies which support and enables to deal with different opinions or any kind of dispute as they arise. Cascón Soriano describes this set of skills as a process, because the abilities built on one another, as shown in the Figure 7.

		CONFLICT RESOLUTION	Calm Analyse Visualize	MEDIATE
	COOPERATION COMPETITION	Games Sports Dances, etc.		VALUES
EFFECTIVE COMMUNICATION/ CONSENSUS	Active listening/ Precise language Channels of communication Decision-making			ORGANIZE THE SCHOOL/ THE CLASS
GROUP BUILDING	Trust Appreciation Knowledge Introduction			EDUCATOR'S ATTITUDE

Figure 7: Abilities of Provention

Source: Paco Cascón Soriano 2001, 12

The four steps include group-building, communication and consensus, working on cooperation, and conflict resolution. The process is starting with group building activities to create a climate of trust and responsibility, high self-esteem and appreciation of others orientated on personal and cultural values. The second step includes communication and the process of consensus decision-making. Thereby is communication with its ability of dialogue, active listening and empathetically communication a fundamental part of non-violent actions. Within this process, it is important to establish a communication channel with a common code, which allows to 'hear' another. Further is the non-verbal communication a crucial factor to understand each other but it has to be coherent with the verbal one. Active listening offers an important ability within communication with its non-verbally elements like eye contact and facing body language. The consensus decision-making process underlines, that "[w]e

have to get beyond head counts and majorities and learn to make decisions in such a way that everyone has had the opportunity to express their point of view and feels that their opinion has been taken into account in the final decision" (Cascón Soriano 2001, 14). By establishing the abilities of *provention*, working in cooperation is the third step which teaches to think in cooperative relationships by using everyone's strengths. The process of *provention* does not keep conflicts away, but it learns to analyse, negotiate and create solutions in a non-violent manner and helps to resolve conflicts (Cascón Soriano 2001, 2-16).

All of these discussed approaches offer different perspectives, ideas and strategies to look at peace, conflict and transformation. The last subsection of this chapter will use the created understanding to focus on two tools which allow to bring these approaches into practice. First, the Circle Process of Kay Pranis and second, the concept of Non-violent Communication of Marshall Rosenberg.

Circles, peace-making circles, are a unique way of dealing and transforming conflicts (Fellegi and Szegő 2013, 9). They have an old tradition, tribal roots and are still existing in the indigenous culture (Pranis 2005, 6). This peace-making practise was used to deal with young indigenous people and their wrongful acts (Törzs 2013, 29). In the last 30 years, circles have also been used among non-indigenous people, especially in individual and community settings. The use of circles within public processes is relatively new. Generally, peace-making circle "bring[ing] people together as equals to have honest exchanges about difficult issues and painful experiences in an atmosphere of respect and concern for everyone" (Pranis 2005, 6). Circles offer a space in which divergent perspectives, anger, pain about conflicts can be shared. By leaving the circle a good feeling about oneself and the others is spread (Pranis 2005, 3-6). The philosophy which frames circles is the recognition "that we are all in need of help and that helping others

helps us at the same time" (Pranis 2005, 6) and the non-hierarchical and inclusive approach (Fellegi and Szegő 2013, 9). Special about circle is, that everyone is giver and receiver and benefit from the common wisdom. Circle bases on life experiences and wisdom and creates a new understanding of situations and solutions. The ancient wisdom of community combined with the current values as respect, needs and differences create a process that:

- "honors the presence and dignity of every participant

- values the contributions of every participant

- emphasizes the connectedness of all things

- supports emotional and spiritual expression

- gives equal voice to all" (Pranis 2005, 7).

Circles are used as a tool of community-building because it engages and connects people in a deep way. Within the philosophy of restorative justice, peace-making circle, are used in the justice system in North America, to include all who are affected by the crime – who committed crime, who are harmed by crime, the community and the justice system (Pranis 2005, 9). This is as well the main difference between mediation and circle, besides the members of the community are state officials part of the circle (Törzs 2013, 30). Furthermore, circle differs from mediations and conferencing in its framework which base on ceremonies and rituals, its unique dynamic in dialogues, the potential to create capital rules and values of the discussion and the consensus-based decision which include all participants (Fellegi and Szegő 2013, 13-14). The goal is to understand each other and to create strategies of repairing and healing. The range of the fields in which circles can be applied is big, which is due to the fact, that it respects the individuality of everyone, it is versatile and hold the wide range of emotions as shown in Figure 8.

A peacemaking circle is a way to bring people together in which:	Peacemaking circle are useful when two or more people:	The peacemaking circle is strong enough to hold:
• Everyone is respected • Everyone gets a chance to talk without interruption • Participants explain themselves by telling their stories • Everyone is equal-no person is more important than anyone else • Spiritual and emotional aspects of individual experience are welcomed	• Need to make decisions together • Have a disagreement • Need to address an experience that resulted in harm to someone • Want to work together as a team • Wish to celebrate • Wish to share difficulties • Want to learn from each other	• Anger • Frustration • Joy • Pain • Truth • Conflict • Diverse world views • Intense feelings • Silence • Paradox

Figure 8: Field of Applications of Circle

Source: Pranis 2005, 8-9.

Furthermore, a peace-making circle is creating various possibilities for freedom: "freedom to speak our truth, freedom to drop masks and protections, freedom to be present as a whole human being, freedom to reveal our deepest longings, freedom to acknowledge mistakes and fears, freedom to act in accord with our core values" (Pranis 2005, 11). In the general setting of a Peace Circle are sitting the participants in a circle of chairs without tables, which symbolises connection, inclusion and equality and they are placing important objects in the centre as a reminder of their common ground. The monotone structural elements – order, talking object, facilitator, guidelines and consensus decision-making – giving the participants a space to be safe and authentic. The part of relationship-building like the creation of the foundation through naming of values, discussing guidelines and call attention on unseen aspects of the participants is taking a major part in a circle. This foundation is relevant for creating a space of dialogue (Pranis 2005, 43). Pranis bases the process of relationship building on the framework of the Medicine Wheel, used by the Native Americans. This frame includes four parts which must be balanced. Starting with the introduction and the meeting – the body is represented, by building trust – the heart is recognised, with the identification of the issue

– the mind of the participants is included and by developing an action plan – the spirit of everyone is part of the circle (Pranis 2005, 43). "Wisdom in a Circle is accessed through personal stories. In a Circle, life experience is more valuable than advice. Participants share their experiences of joy and pain, struggle and triumph, vulnerability and strength to understand the issue at hand" (Pranis 2005, 13). Besides the structure and the overall goal differ the various circles in their function. The names of the different types are not fix but reflect the major intentions. There are Talking Circle, Circle of Understanding, Healing Circle, Sentencing Circle, Support Circle, Community-building Circle, Conflict Circle, Reintegration Circle and Celebration Circle (Pranis 2005, 3-17).

The second tool discussed is the concept of Nonviolent Communication of Marshal Rosenberg.

Marshall Rosenberg developed the approach of Nonviolent Communication (NVC) which refers to the natural state of compassion in the beginning in the 1960s. Rosenberg explains violence, or a behaviour of harm as a strategy in which the personal needs are not met. This means that NVC "[...] strengthen[s] our ability to remain human, even under trying conditions" (Rosenberg 2015, 3). NVC is a language and communication skill which helps us to hear the others and express ourselves. While practising NVC "[...] old patterns of defending, withdrawing, or attacking in the face of judgment and criticism" (Rosenberg 2015, 3) will be replaced by a language which talks from heart to heart. The NVC model is a process, which has four components – Observation, Feelings, Needs and Requests. Each of the four steps are necessary to create an environment of respect, attentiveness, honesty and empathy which are the basis of a peaceful state of mind. Old behaviour patterns of resistance, violent reactions and defensiveness are reduced in a conversation and the focus turns from judging and diagnosing towards "what is being observed, felt, and needed" (Rosenberg 2015, 3-4).

Respect, empathy and attentiveness is generated through the emphasis on deep listing to ourselves and to others.

Rosenberg is differentiating between the language of the 'Jackal' and the 'Giraffe'. The Jackal stands for: aggression, judgement, blame, excuses, punishment, reward, demand, and dominance. Whereas the giraffe language represents connection, no judgement, observation, responsibility, feelings, and needs which are known. Rosenberg chose the giraffe because it has the biggest heart of the mammals. The giraffe represents the NVC strategy, the compassion, the open-hearted language, and the clear-sighted intension of the speaker (Rosenberg 2013, 1-4).

To understand the four steps of the NVC completely, they will be discussed in detail now.

Observation means to answer the question: 'What is happening in the situation?' without adding an evaluation. The point is to formulate a clear observation without mixing facts and opinions or introducing judgments or evaluation into the observation, even though the person is doing something that 'I do not like'. Rosenberg summarises this with the words, that "[w]e need to clearly observe what we are seeing, hearing, or touching that is affecting our sense of wellbeing, without mixing in any evaluation" (Rosenberg 2015, 26). The reason of not mixing observation and evaluation is, that an evaluation will be heard as criticism. Furthermore, generalisations are a characteristic of a static language and the opposite of the process of language on which the NVC bases on. Wendell Johnson explains this problem as follows:

> "Our language is an imperfect instrument created by ancient and ignorant men. It is an animistic language that invites us to talk about stability and constants, about similarities and normal and kinds, about magical transformations, quick cures, simple problems, and final solutions. Yet the world we try to symbolize with this language is a world of process, change, differences, dimensions, functions,

relationships, growths, interactions, developing, learning, coping, complexity. And the mismatch of our ever-changing world and our relatively static language forms is part of our problem." (Johnson within Rosenberg 2015, 26)

Observation is always linked to time and context which stands in contrast to generalisation.

Through the question of "how we feel in relation to what we observe" (Rosenberg 2015, 7) the own feelings are introduced into this process. In our daily life, feelings are much discussed, but not in a truthful and honest way. Because of socialisation the connection to ourselves is missing, and the 'right way to think' does not include our feelings. Rosenberg even says that we are through socialisation "trained to be 'other-directed' rather than to be in contact with ourselves" (Rosenberg 2015, 37). The english language supports this argument by using the word *to feel* before expressing an opinion and not a real feeling. This raises the question which words express feelings and which do not. After 'I feel' follows often a "that, like as if", "I, you, he, she they, it" or names or nouns which do not express a clear feeling, for example: "I feel that you should know better"; "I feel it is useless" or "I feel Amy has been pretty responsible" (Rosenberg 2015, 41). Furthermore, there are words which express actual feelings and those which expresses what we think we are or how we think others are behaving. "I feel inadequate as a guitar player" is an example for a description of what we think and can be translated into "I feel disappointed in myself as a guitar player". Whereas "I feel misunderstood" expresses the behaviour of other people and not the personal feelings (Rosenberg 2015, 41-42). All these expressions can be heard and understood as criticism, which underlines, that the word 'feel' is often used but real feelings are not expressed.

The difficulties of expressing the feelings can be explained on the one hand by the socialisation and the other hand the missing vocabulary. That is why a list of feelings

(Annex 6) exists within the approach of Rosenberg. The goal of this approach is to express the feelings in an adequate way and identify the emotions behind. Behind every feeling lies a need, which has to be satisfied. Feelings are arranged in two groups. The first one lists feelings where the needs are met and the second one where the needs are not met. Rosenberg underlines that there is no division between positive or negative feelings. The acknowledgement of the root of our feelings is important. This awareness is important when dealing with negative messages. NVC explains, "that what others say and do may be the stimulus, but never the cause of our feelings" (Rosenberg 2015, 49). Rosenberg explains that there are four ways of handling this negative message – "blame ourselves, blame others, sense our own feelings and needs, or sense others' feelings and needs" (Rosenberg 2015, 60). The first two are not taking feelings into consideration, in contrast to the third and fourth one. NVC is going one step further and requires to connect the own feelings with the own needs – 'I feel ... because I need ...' (Rosenberg 2015, 37-49).

The clarification of the own needs is the third step within this process. Even by talking about something which is needed the real needs and the connection to oneself or between people are often not expressed. Needs, like connection, honesty, peace, love, belonging, or understanding are just few examples of the needs Rosenberg is talking about (Annex 6). "The needs, values, desires, etc. that create our feelings" (Rosenberg 2015,7) must be clarified and defined. The clarification is important, to avoid needs being mixed up with requests. Requests might result in the speaker asking the listener to satisfy his needs and in the message, being received by the listener as negative criticism. Like feelings, a clear formulation of one's own needs forms the basis for NVC and the connection between people. Socialisation influences that people, especially women, are often caring more about others than about themselves and their needs. Important for the is to identify the own needs but also the ones of the other person within a conversation.

Similar to the correct expression of feelings, it is a challenge to formulate needs clearly and to listen and discover the needs of others even if they are covered by blame or criticism. Furthermore, criticism, judgments, diagnoses, or interpretations, are heard by the conversation partner if the own needs are not satisfied, and the other person is blamed for it. It is important, that needs are fulfilled because they impact the feelings (Rosenberg 2015, 49-66).

The fourth and last step of this process is the formulation of a request. "The concrete actions we request in order to enrich our lives" (Rosenberg 2015, 7) express the last step of the NVC process. Rosenberg points out three main requirements when posing requests. First, to use positive language, which means to formulate what is wanted and not what is not wanted. Second, to formulate a concrete action and not a vague or abstract phrase, which can be misunderstood, and lastly, to know the difference between demand and request. If people are hearing a demand, they just perceive two options to react: submission or rebellion, while a request allows to accept or reject (Rosenberg 2015, 67-90).

Summed up, the four steps of NVC start with an observation of the situation without mixing in evaluations. Second is the listening to oneself and clarifying the feelings, because they are the expression of the needs which are met or not. The third step is the acknowledgement of the needs behind the feelings and the realisation, that the messages sent by people is never the cause of one's personal feelings. The fourth step is the formulation of a request to fulfil one's needs in a positive, clear and action language.

The main point is, that a connection to us and to the other person is obligatory to talk from heart to heart. This connection and the honesty about feelings and needs create the basis of NVC. By being connected a space is created where feelings, needs and

vulnerability can be shared and cared. Within this space strategies can be found to meet the needs of both.

4.5. Peaceful Transformation Towards a Humanised Childbirth

In the sub-chapters above the paper analysis three aspects. First, the paper presents and discusses five national and international actors and their approaches, guidelines and ideas regarding humanised childbirth. Second, the paper looks at changes the main groups of actors around childbirth have to make. Third, the paper considers the impact of research within humanised childbirth, concepts, approaches and tools of peace study. These analyses lay the basis of a comprehensive and interdisciplinary transformation.

This subchapter combines all the actors, approaches, guidelines and tools which have been presented and create a proposal to transform dehumanised into humanised childbirth. This proposal is not claiming completeness or standing for a universal solution, it is more a merge of existing international and national guidelines and ideas and their effects with additional tools to support the transformation towards humanised childbirth.

This proposal is the result of this research and a personal perspective of a possible transformation. Figure 9 visualises this proposal and the merge of the discussed actors, guidelines, effects, approaches and tools. The left side of the figure visualises current measures and status quo of literature which focuses rather on structural elements and quality of care. The right side of the figure needs to be added based on this work, which emphasises the cultural change of the current birth culture and the understanding of peace. In the following paragraph, this paper describes first the left side of the figure and then the right side.

The change of birth perception is influenced by various actors. The five discussed and most relevant actors are (UN-recommendations, WRA-charter. Policy guidelines,

Mother Hood e.V., ICI -quality of care). All of them are directed towards the healthcare policy which is asked to provide financial support in different areas to counteract the deficits in research, structure and education. The three deficits have a different focus. Finance research deficits and finance structural deficits are rather focusing on structural elements whereas finance education training has a focus on the quality of care.

Below each deficit, the figure summarises the umbrella terms of the guidelines and main aspects which were mentioned most frequently within the research.

The first area finance research deficit highlights the following three aspects: the expansion of the cross-sectoral cooperation, the research on low-evidence topics and various data collections to derive measures and evidence-based practises. The second area finance structural deficits focus on the compensation of the financial deficits within midwifery. Thereby health policy is asked to increase the financial resources for medical staff and assistance and the budget for developing further evidence-based guidelines. Education/training is the third area in which the health policy is requested to finance. This includes the quality-driven knowledge of need-based continuous care, evidence-practises, human rights instruments and existing regulations. This knowledge is including further aspects like information sheets, transparency and national laws. These finance education/training should be made available for the healthcare provider and WomenBaby-Family units.

All three deficits influence the healthcare providers and evoke a change of 'habits' and with it a reduction of obstetric violence. This is the plan and the way of thinking of most guidelines and actors.

The changes which are needed and requested to create the change of habits can be based on structural elements or quality of care. Driven by financial support, structural changes and knowledge, the deficits are decreasing, and habits can change. Structural

elements can, on the one hand, decrease the rate of interventions, medicalisation, workload and routine, and can on the other hand increase information content and time of the medical staff. Furthermore, the change of habits can be driven by an increase of quality of care. This includes discussions and implementations of topics like respect, dignity, discrimination, empathy, WomenBaby-Family care, harmful practises, teamwork and dialogue. The goal is, that through the change of habits, behaviour and views, childbirth becomes more humanised.

This left side of the figure focuses on the one hand on structural elements which can be changed more easily through financial support and on the other hand on the quality of care which can be changed by education and trainings. The more we go to the right the more the quality of care gets relevant. Overall it reduces the complexity of dehumanised childbirth which has been presented and explained in this thesis.

The right side of the figure considers the current birth culture which has been elaborated within this paper and which has not been the focus of other research so far.

The current birth culture is influencing the health policy, the healthcare provider and the WomenBaby-Family unit and needs to be included in this figure. A cultural change is not happening overnight or just because of a one-sided change. The main aspects which need to be changed through a cultural change are the positive view on the medicalisation and interventions, childbirth as a pathological event and the hierarchical structure between medical staff. Furthermore, trust in the ability to give birth has to return to the women and guide the birth culture.

As mentioned above the current birth culture impacts WomenBaby-Family and they also have to be taken into account regarding a change. They also require a change of perception. For this, they must benefit from the education and training programs that are coming from the rather structural elements. The goal is, that the WomenBaby-Family unit

increases amongst other aspects of their self-determination, self-confidence, experience and demand for empathy and have less fear of childbirth.

Besides the so far mentioned elements, this proposal includes the elements of peace studies. The tools, Peace Circle and NVC, underpinned by five selected approaches of peace, conflict and conflict transformation. These five are just representing a selection out of the diversity of peace studies and are not collectively exhaustive. Due to this, they are visualised as pieces of a whole.

Generally, the idea is, that through the tools and the understanding of peace, conflict and conflict transformation the habits of the medical staff, the perception of the WomenBaby-Family unit and the cultural understanding of childbirth can be supported in their process of transformation towards a humanised childbirth.

Overall the structural elements, the quality of care and the current birth culture forms a circle which includes all actors, actions and reflections to reach a humanised childbirth. Humanised childbirth can only be reached then everything involved is iteratively reflected.
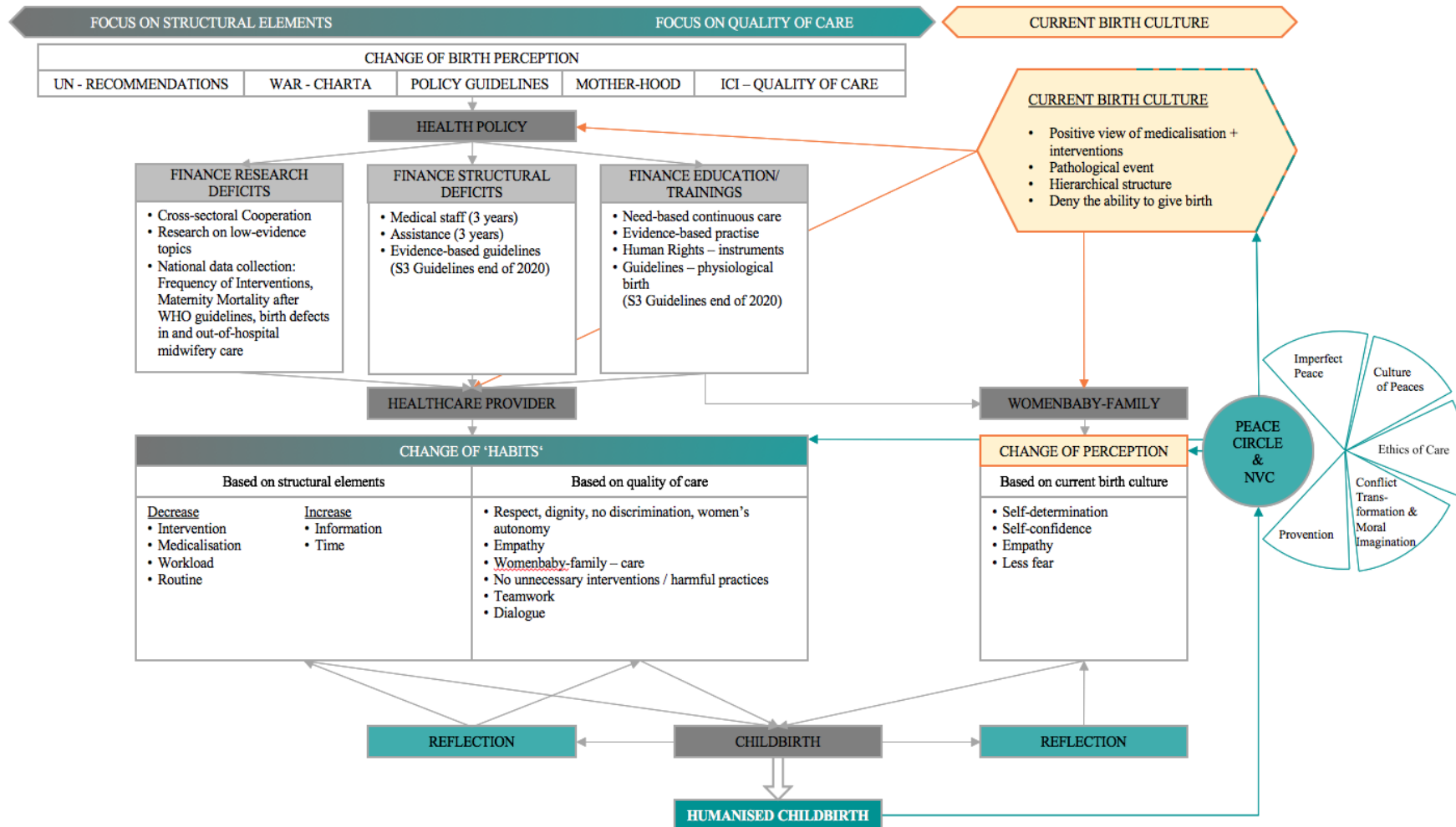
Figure 9: Peace Proposal - Humanised Childbirth.

Source: own idea and presentation

The following paragraphs of the paper are connecting the guidelines and ideas of the different actors with the concepts of peace study and bringing them through Peace Circle and NVC into praxis. This is the last step of showing how an interdisciplinary transformation towards a humanised childbirth in Germany guided by various ideas of different actors can look like. The focus is on Peace Circle and NVC and the way these two tools can support and strengthen the process of transformation of groups and individuals within humanised childbirth.

By starting this transformation, it is important to transmit the understanding of peace, based on the previous discussed concepts, that it is a process that gets strengthen through peace values and the structures of peace. This process enables us to promote, recognise and interact with the complexity and with all pieces of peace. It is an imperfect road that will need to be developed, changed and adapted constantly. This understanding is strengthening the culture of peace and with it the culture of caring. The capacity to care is fundamental for the development of a peaceful transformation, as it is based on relationships and responsibility. With this fundamental understanding of peace another puzzle piece of this mosaic– conflict – can be added to the knowledge of transformation.

Conflict is a part of human life, it is a motor of change and it is a process that needs time to arise and time to be transformed. Transformation is showing the horizon of the journey by building healthy relationships. Qualitative relationships are in a constantly changing and adapting process. In the process of transformation, the web of relationships must be understood and recognised. This includes especially the individual part within the web. Furthermore, complexity must be accepted and seen as a friend. Through creativity, a space is created which opens up new and unseen possibilities. Lastly, the risk within the change must be accepted.

By summarising the main ideas of peace, conflict and transformation it becomes clear, that these concepts of peace studies are supporting the transformation towards humanised childbirth. There are good and sufficient programs and guidelines available which need to be implemented completely before further programs and adjustments are needed. The idea is to stop focussing on defects, grievances, violence and dehumanised childbirth and to start showing new possibilities of supporting a cultural of change towards humanised childbirth. The orientation on the concept of provention provides a rough guideline on how the knowledge can be transmitted. The focus on pre-crisis interventions creates a breeding ground for a long-lasting change.

The concept of provention of Cascón Soriano (2001) has two objectives. Firstly, the transmission of the understanding of peace, conflict and transformation. Secondly the creation of capacities of trust, relationship, responsibility, dialogue, non-violent action and communication and cooperation.

The goal of this proposal is to strengthen both groups medical staff (obstetrician and midwives) and the WomenBaby-Family unit, by receiving the described knowledge and understanding of peace and conflict, and by being trained in the Peace Circle and NVC. These pre-crisis interventions after Cascón Soriano (2001) include three steps. First step: group-building activities. Second step: communication. Third step: cooperation. These steps will be explained within the context of this transformation towards humanised childbirth in the following three paragraphs.

Within the first step, the focus is on group-building activities, trust-building measures, relationship building, responsibility and self-esteem. Trust has within this transformation three elements which have to be built up: first the trust in oneself, second the trust in women and their ability to give birth and third the trust in the strength of a humanised childbirth without unnecessary interventions. The building and strengthening

of relationships is a key element of the transformation. The relationship between women and the medical staff needs to be empowered. A good relationship is the basis of a culture of care, for a healthy transformation, peacebuilding and communication.

The second step is focussing on communication which includes, for example, the training and implementation of a consensus decision-making process. All of the discussed programs encourage to implement a consensus decision-making process aligned with human rights and informed choice. By promoting dialogue, active listing and empathetically communication the capacity of NVC will be included. NVC is important, because it goes along with culture of peace, culture of care and conflict transformation. It is seeing violence as unmet needs and promoting dialogue with compassion and from the heart to heart. Listening to oneself, analysing the feelings and the needs and listening to the other(s) are crucial factors to increase the quality of care. By listening to the feelings and needs of the WomenBaby-Family unit they will be respected and cared for. Additionally, listening to the feelings and needs of the medical staff creates a healthy work environment where respect and teamwork are lived. Furthermore, communication can also be improved by the promotion of non-violent action and the creation of a communication channel. These two elements working directly against obstetric violence, by promoting freedom, equality, dignity and respect. The communication channel underlines the importance of listening, hearing and seeing the women during all stages of labour and childbirth. Especially the psychological violence which is based on gestures, pictures and words (insults, threats, extortion, laughing or shouting) will be minimised by creating a common communication channel.

The third step is the building of cooperations to use everyone's strength within the setting of childbirth. This means to recognize every single one within the web, including

its importance and strength. These cooperations deconstruct the hierarchy within the medical staff, towards WomenBaby-Family unit and between cross-sectoral actors.

By using the frame of provention and including NVC a solid base is created to strengthen every actor to transform towards a humanised childbirth.

However, the feedback circle of this transformation is including the reflection part, which requires a safe space. For this reason, peace-making circles need to be implemented in the beginning and in between the transformation process. Different types of circles can be used to combine different groups and thematise different topics. Three types of circle will be explained in the following paragraph.

The circle of understanding gives the opportunity to understand aspects of dehumanised childbirth, especially obstetric violence, and to create a more complete picture of this context. This circle could help to create an atmosphere of respect and a (cross-sectoral) community between actors. Apart from the discussed actors, further actors like politicians, the pharmaceutical industry, different scientists, fathers / live partners and society could be included within circles. A circle of understanding can also be used for pregnant women to give the fear, the doubts and the questions a safe space.

The second type of circle is the conflict circle which can help to resolve differences. Thereby topics of the macro-level such as hierarchy, the distribution of work or different approaches of midwifery (pathogenetic or salutogenetic approach) could be discussed.

Thirdly the healing circle creates the space of sharing pain, experiences and trauma which is important for the WomenBaby-Family unit and medical staff to process the incidents of dehumanised structures.

The goal is to create a space that can hold an honest exchange with an atmosphere of respect to include everyone and to create strategies.

In summary, the input of the understanding of peace, conflict and transformation through the supportive system of provention, NVC and circle represent a solid frame to stimulate, implement, support, and hold a transformation process of a cultural change towards a humanised childbirth. Furthermore, the elements of transformation towards a humanised childbirth will be created and supported. The individualisation and humanisation of the women will be honoured through respect, communication and relationship. Empathy and moral engagement will be lived through the compassion of NVC. The structural elements, education and evidence-based knowledge will be guaranteed through the financial supports in research, structure and education and the understanding of approaches of peace studies.

4.6. Conclusion of the Proposal

Concluding this proposal, the goal of humanised childbirth is reached. The women and their children are back in the centre of the perspective. However, the whole proposal is a web and a circle in which everything is interconnected. Thereby the needs of the medical staff are included and respected, too. The condition of this proposal is, that this transformation and cultural change need time and the support of the different actors in society to make the humanised childbirth the new normal and to be recognised as an imperfect peace proposal.

5. Conclusion

5.1. Summary of main Findings

This study aimed to show the importance of a humanised childbirth regarding the relationship between mother, child, family and healthcare provider and the value of birth as a crucial point in life which needs to be respected. Furthermore, this work intended to create an understanding for a positive change within society towards a humanised childbirth and to stop victimising and simplifying the complexity of the web of involved actors, the types of violence and the ways of transformation.

This research provided background knowledge of humanisation and dehumanisation of childbirth, their characteristics and forms in the German setting as well as an understanding of peace, conflict and transformation to create the capacity for a peaceful transformation.

Initially, the first piece of the mosaic – humanisation of childbirth – was roughly outlined. This overview showed the importance of considering the philosophical understanding and its dimension of humanisation in order to provide a space of creativity within the transformation. A strict set of elements of humanisation would have led to the creation of a simplified picture of possible actions and reactions. This research concludes that the concept of humanisation of childbirth should be understood with its imperfections. No single understanding of viewing, hearing, acting and understanding childbirth exists. Thus, no 'one' concept can be implemented in various settings as a 'blue print'. With feelings of security and trust being created during pregnancy, birth and postpartum, humanised childbirth is a fundamental right of every human.

The analysis of the second piece of the mosaic – dehumanised childbirth – elucidated its complex character intertwining the process of medicalisation, the forms of obstetric violence, the understanding of safety and childbirth. The existence of

dehumanised structures causes direct, structural and cultural violence in form of violent actions, routine procedures, structural deficits, lack of knowledge and research, stuck cultural understandings as well as the underestimation of the impact of these dehumanised procedures. This study highlights that any kind of obstetric violence is affecting various actors and their relationships. The implications of these dehumanised structures are greater than previously understood. Even though a vast number of evidence emphasises the impacts of dehumanised childbirth, most structures occur during non-evidence-based procedures which follow a daily routine and do not consider their impact. As long as medicalisation and unnecessary interventions are normalised, accepted, and for over 90% of the birth reality, the needs of the women, of the children as well as of the healthcare providers are not met.

The goal of this research was to see, listen and respect various actors, as well as to include and give them a voice within the process of transformation towards a humanised childbirth. The analysis of the current situation in Germany, the various actors and their ideas of transformation, revealed the need for a transformation towards humanisation of childbirth. This transformation is not only required due to the previously highlighted importance and positive impact of humanised childbirth, but also due the right of every birthing woman to experience a self-controlled and protected birth. On the one hand, a humanised childbirth is supported by the relationship between mothers, medical staff and their families. On the other hand, a humanised childbirth strengthens the relationship between birthing women and their child.

This study provides an approach to disrupt and end the cycle of violence within dehumanised childbirth. It highlights that scientific proof, more financial resources and research are not enough to change the perspective on the (German) birth culture. Therefore, this work proposes the strengthening of humanised elements such as

cooperation, relationship, communication, compassion, connection, care and love of every actor within childbirth and the spread of the philosophy of peace. The different concepts of peace, conflict and transformation complement the given pieces of the mosaic with their richness of creating new conjunctions. The inclusion of various actors, approaches, concepts, understandings and perspectives allowed to create new conjunctions within the web of humanised childbirth and to discover where peace(s) lied.

The understanding of humanisation as something imperfect and unfinished creates the possibility of changes, alternatives and adjustments on the way of development and transformation. Respecting the complexity of dehumanised and humanised structures provides a chance to include various actors and perspectives. Further, the focus on the needs of the various actors allowed the creation and care of connections and relationships. Additionally, this work provides an opportunity to change the perception of childbirth in Germany and allows it to become a common concern of society. The understanding of the richness of creativity and imagination further helped to explore and discover new ways of transformation. No 'one' type of peace exists, but rather many forms of peace and humanised childbirth.

The proposal provided by this research is a specific approach for the selected study setting and topic of dehumanised and humanised structures in the German hospitals. Even though the understanding of peace and the tools of NVC and Peace Circle can be implemented in various contexts, it is important to respect the cultural surroundings.

By offering NVC and Peace Circle as (self-)caring procedures, the individuals and the groups are strengthened which in turn supports the process of transformation. The analysis showed, that the aspect of (self-)care is crucial within humanised childbirth and is neglected in various concepts of transformation Thus, this proposal focused on (self-

)care. However, this proposal does not represent a solution, but should rather be understood as a supportive element towards the journey of transformation.

Furthermore, this proposal may provide me, a peace-maker with my personal expertise in NVC and Peace Circle, the possibility to become part of this transformation.

I would like to conclude this study with the following message regarding the simple reason why we have to change the understanding about and the action during childbirth: the "[...] humanity owes the child the best it has to give […]" (BMFSFJ 2014, 36)[2]. Humanisation of childbirth is the best approach to welcome the children in a peaceful way, to demonstrate a respectful and love-based togetherness which is based on relationships and cooperation and to give them a protected start into this world.

5.2. Limitations

During this research, expected limitations were confirmed and new ones were experienced. The expected limitation provided through the generalisation of all birthing women in German hospitals was confirmed. However, every birth is a unique experience and takes place in its own setting with every woman experiencing birth in a different way. This experience is firstly depending on the individuality of each woman, her medical conditions, her health and her lifestyle. Secondly, the medical staff, its knowledge, experience and understanding of care as well as childbirth affect each childbirth. Lastly, the structural settings including hospital administrations, logistics, workload and timing impact each birth experience. Another known limitation was presented through the

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[2] Own translation from German: „[…] die Menschheit schuldet dem Kind das Beste, das sie zu geben hat […]" (BMFSFJ 2014, 36)

generalisation of the cultural and social economic diversity within Germany, which disregarded underlying structures, behaviours, prejudices or forms of discrimination.

While the selection of the actors was broader in comparison to most of the other studies, it still excluded uncountable other actors from various sectors. Each actor would have added new perspectives, needs and capacities for transformation and expanded the web of humanised childbirth. Therefore, a balance between the complexity and the stated limitations is important.

The focus on German hospitals allowed the depth of this analysis, but excluded the possibility of holistically understanding the widespread phenomenon of dehumanised childbirth. This leads directly to another limitation, the cultural understanding of living, caring and birthing. The focus on Germany only allowed the analysis of one birth culture, while the inclusion of various understandings could have enriched the view of childbirth. Besides this cultural diversity various narratives of violence exist. Thus the use of a more general understanding of violence influenced the perspective on obstetric violence.

Due to time constraints, I did not use field research or my own experience to conduct this study. Since childbirth is a societal concern interviews with various (German) people would have enriched the views, perspectives and experiences presented and analysed through this research.

Finally, my personal abilities and expertise has influenced this research. Through the review of English and German articles, other perspectives of scholars could were neglected which limits the scope of this research. Although my intension was to create an open space of raising consciousness and understanding of the importance of childbirth, I am aware of my position as a woman and a peace-maker which bears the risk of bias and emotional involvement.

5.3. Further Research

Besides the limitations of this work, opportunities of further research should be taken into account. The understanding of the prenatal, natal and postnatal time as a continuum highlights that birth should not be separated from the other periods of pregnancy. Therefore, impact of the prenatal influences on birth and the postnatal period should be considered. The inclusion of this continuum will allow an expanded understanding of the German birth culture.

Furthermore, a philosophical and social understanding of humanisation, of what it means to be human, a woman, a mother or a midwife enriches the understanding of the concept of humanisation and its key elements. Further, would be interesting to include other cultural perspectives of birth to discuss the richness and importance of it.

This is a beginning of a journey, in which I would like to participate as a peace-maker and transform dehumanised structures. I sincerely hope that my research provides a contribution to the current discussion and creates space for new perspectives of transformation towards a humanised childbirth.

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Annex

Annex 1

United Nations, 2019, the report "A human-rights approach to mistreatment and violence against women during reproductive health services with a focus on childbirth and obstetric violence".

Recommendations for States and stakeholders regarding mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence of the UN (2019)

I - The first six points general recommendations:

1- States have an obligation to respect, protect and fulfil women's human rights, including the right to highest standard attainable of physical and mental health during reproductive services and childbirth,

2- States should address the current problem of mistreatment and violence against women in reproductive services and childbirth from a human rights perspective

3- States should establish constructive cooperation between health institutions and professional associations with women's non-governmental organizations, women's movements and independent human rights institutions dealing with reproductive and obstetric care.

4- States should also elaborate national strategies on reproductive health services and childbirth in order to secure respectful and caring human rights- based treatments in the context of childbirth and other reproductive services, in line with international women's human right standards, including respect for privacy and confidentiality.

5- States should address:

   a. structural problems and underlying factors within reproductive health-care systems that reflect discriminatory socioeconomic structures ingrained in societies;

   b. the lack of proper education and training on women's human rights for all health professionals;

   c. the lack of qualified staff and the resultant heavy workloads in health-care facilities; and

d. budgetary constraints. States should allocate adequate funding, staffing and equipment for maternity care wards and facilities, in line with international human rights law, which requires that States devote the maximum available resources to sexual and reproductive health, including maternal health and childbirth programmes.

6- Women's human rights include their right to receive dignified and respectful reproductive health-care services and obstetric care, free from discrimination and any violence, including sexism and psychological violence, torture, inhuman and degrading treatment and coercion (UN 2019, 21).

II - The second part of the recommendations is focussing on the question of consent to prevent violence against women

a. Ensure the effective and proper application of informed consent, in line with human rights standards;

b. Adopt effective health laws and policies for the application of informed consent in all reproductive health services and guarantee prior, free and informed consent for caesarean sections, episiotomies and other invasive treatments during childbirth;

c. Respect women's autonomy, integrity and their capacity to make informed decisions about their reproductive health (UN 2019, 21).

III - The third part is listing prevention of obstetric violence:

a. Guarantee women's right to a birth companion of her choice in law in practice;

b. Consider the possibility of allowing home birth and avoiding the criminalization of home birth;

c. Monitor health-care facilities and collect and publish data on the percentage of caesarean sections, vaginal births and episiotomies and on other treatments related to childbirth, obstetric care and reproductive health services on a yearly basis;

    d. Apply women's human rights instruments and WHO standards related to respectful maternity care, intrapartum care and violence against women;

    e. Address the lack of anaesthesia and pain relief, lack of choice of birth position and lack of respectful care (UN 2019, 21).

IV – Fourthly the accountability of the states is formulated:

    a. Establish human rights-based accountability mechanisms to ensure redress for victims of mistreatment and violence, including financial compensation, acknowledgement of wrongdoing, formal apology, and guarantees of non-repetition;

    b. Ensure professional accountability and sanctions by professional associations in cases of mistreatment and access to justice in cases of human rights violations;

    c. Guarantee full and fair investigations into allegations of mistreatment and violence against women during childbirth;

    d. Ensure that women victims of violations are provided with adequate remedies, which may take the form of restitution, financial compensation, satisfaction or guarantees of non-repetition;

    e. Ensure that regulatory bodies, including national human rights institutions, ethic commissions and ombudspersons and equality bodies have the mandate and resources to exercise oversight over public and private birthing facilities to guarantee respect for women's autonomy and privacy;

    f. Raise awareness among lawyers, judges and the public about the women's human rights in the context of childbirth to ensure the effective use of remedies (UN 2019, 21).

V- Discriminatory laws and harmful gender stereotypes

    a. Review and strengthen laws that prohibit all forms of mistreatment and violence against women, including psychological violence, during pregnancy and childbirth and other reproductive health services in line women's human rights instruments;

b. Abolish any mandatory husband, relative or similar authorization for reproductive health services which concerns women;

c. Repeal laws which criminalize abortion in all circumstances, remove punitive measures for women who undergo abortion, and at the very minimum, legalize abortion in cases of sexual assault, rape, incest, and when the continued pregnancy endangers the mental and physical health of the woman or the life of the woman, and provide access to safe, quality post-abortion care;

d. Remove criminal charges and imprisonment of women who have been seeking emergency obstetric health services, including due to miscarriages, and remove punitive measures against doctors in order to enable them to provide the needed medical support;

e. Prohibit and address practice of forced sterilization procedures, especially with respect to women belonging to a minority and indigenous women, improve safeguards against such human rights violations and provide appropriate redress and compensation for victims;

f. Address the intersectional discrimination or compounded stereotypes experienced by subgroups of persons

(UN 2019, 21 own presentation).

Annex 2

Request of the Fraction Alliance 90/The Greens (Bündnis 90/Die Grünen), 2020,

'Cultural change in midwifery – focusing on women and children'

I. with the aim of improving the quality of obstetrics and strengthening the freedom of choice of birthplace

1- To introduce a personnel assessment tool for midwifery care in delivery rooms, which assumes a 1:1 care of the pregnant woman by a midwife during essential phases of birth;

2- To require hospitals to publish their midwifery care allocation and measures in place to reduce their risk-adjusted C-section rate;

3- To adjust the remuneration of spontaneous births (physiological births) and C-sections;

4- To support the nationwide establishment of midwife-directed delivery rooms;

5- To ensure cross-sectoral quality assurance in obstetrics, including the standardised documentation of clinical and non-clinical-midwifery births and birth processes;

6- To implement a nationwide standardised recording and analysis of maternal deaths according to the guidelines of the World Health Organization;

7- To establish a national action program for the prevention of birth defects with a register to record and analyse all birth defects and their associated risk factors in connection with clinical and nonclinical births;

8- To ensure that obstetricians inform pregnant women of their entitlement to midwifery assistance according to § 24d SGB V; further this entitlement should also be highlighted in the maternity pass;

9- To support pilot projects ensuring safe obstetrics in regions with low birth rates within the innovation fund for new care models;

10- To evaluate and extend the possibilities of paternity leave for the partner of the pregnant woman with regards to the employer;

11- To ensure public information about the rights of the pregnant/birthing woman to a self-determined pregnancy, birth and the puerperium and the creation of specific contact points or rather the use of existing contact points for those affected by violence in obstetrics;

II. with the aim of improving working conditions in obstetrics

1- To refinance tariff increases for employed midwives in maternity clinics according to certain quality criteria, such as 1:1 care in significant phases of the birth;

2- To arrange the payment of safety margins to support the work of midwives in underserved regions;

III. with the aim of health promotion

1- To conduct a nationwide campaign and continuous public relations work to raise awareness of the benefits of physiological births, aimed at both future parents and obstetrics professionals;

2- To anchor the national health goal "Health around the birth" in § 20 paragraph 3 of the Fifth Book of the Social Code and to strengthen public health reporting on women's and children's health in the phases of pregnancy, birth, postpartum and breastfeeding;

3- To promote scientific research on various low-evidence topics such as salutogenetic quality criteria and violence prevention, especially through the targeted support and expansion of midwifery science.

IV. To set up a national forum,

e.g. an "obstetrics summit", to join and cooperate with relevant actors at the municipal, state and federal levels with the aim of developing a comprehensive reform in obstetrics.

(Bündnis 90/Die Grünen 2020, 3-5, own presentation and translation)

Annex 3

White Ribbon Alliance - Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns

Explanation	Legal authority	Regional legal authority
1 – Everyone has the right to freedom from harm and ill-treatment		
No one is allowed to physically hurt you or your newborn. You should both be taken care of in a gentle and compassionate way and receive assistance when experiencing pain or discomfort.	International Covenant on Civil and Political Rights, 1966, Article 7 Convention on the Rights of the Child, 1990, Article 19, 37 Convention on the Rights of Persons with Disabilities, 2006, Article 15, 16	African Charter on Human and Peoples' Rights, 1998, Article 6 African Charter on the Rights and Welfare of the Child, 1990, Article 16 American Convention on Human Rights, 1969, Article 5 American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, 1988, Article 19 Convention of Belem do Para, 1994, Article 2, 3, 4 European Convention on Human Rights, 1950, Article 3

2 – Everyone has the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.		
No one is allowed to force you or do things to you or your newborn without your knowledge or consent. Every woman has the right to autonomy, to receive information, and provide informed consent or refusal for care. Every parent or guardian has the right to receive information and provide informed consent or refusal for their newborn's care, in the newborn's best interests, unless otherwise provided by law.	International Covenant on Civil and Political Rights, 1966, Article 7, 19 Convention on the Rights of the Child, 1990, Article 5, 13	African Charter on Human and Peoples' Rights, 1998, Article 9 American Convention on Human Rights, 1969, Article 13 European Convention on Human Rights and Biomedicine, 1997, Article 5, 6

3 – Everyone has the right to privacy and confidentiality.		
No one is allowed to share your or your newborn's personal or medical information, including all records and images, without your consent. Yours' and your newborn's privacy must be protected, except as necessary for healthcare providers to convey information for continuity of care.	International Covenant on Civil and Political Rights, 1966, Article 17 Convention on the Rights of the Child, 1990, Article 16 Convention on the Rights of Persons with Disabilities, 2006, Article 22	African Charter on the Rights and Welfare of the Child, 1990, Article 10 American Convention on Human Rights, 1969, Article 11 European Convention on Human Rights, 1950, Article 8

European Convention on Human Rights and Biomedicine, 1997, Article 10

4 – Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.		
No one is allowed to humiliate, verbally abuse, speak about or touch you or your newborn in a degrading or disrespectful manner. You and your newborn baby must be cared for with respect and compassion.	International Convention on Civil and Political Rights, 1966, Article 17	African Charter on Human and Peoples' Rights, 1998, Article 6
	Convention on the Rights of the Child, 1990, Article 16, 23	African Charter on the Rights and Welfare of the Child, 1990, Article 13
	Convention on the Rights of Persons with Disabilities, 2006, Article 17	American Convention on Human Rights, 1969, 1Article 5, 11
		Convention of Belem do Para, 1994, Article 4
		European Convention on Human Rights, 1950, Article 8

5 – Everyone has the right to equality, freedom from discrimination and equitable care.		
No one is allowed to discriminate against you or your newborn because of something they think or do not like about either one of you. Equality requires that pregnant women have the same protections under the law as they would when they are not pregnant, including the right to	International Covenant on Civil and Political Rights, 1966, Article 24 (1), 26	African Charter on Human and Peoples' Rights, 1998, Article 2
	International Covenant on Economic Social and Cultural Rights, 1966, Article 2, 10 (3)	African Charter on the Rights and Welfare of the Child, 1990, Article 3

make decisions about what happens to their body.	Convention on the Rights of the Child, 1990, Article 2	American Convention on Human Rights, 1969, Article 1
	Convention on the Elimination of all Forms of Discrimination Against Women, 1979, Article 1, 12, 14(2)(b)	Convention of Belem do Para, 1994, Article 6
		European Convention on Human Rights, 1950, Article 14
	Convention on the Rights of Persons with Disabilities, 2006, Articles 5, 6, 7	
	Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990, Article 14	
	International Convention on the Elimination of All Forms of Racial Discrimination, Art. 2, Art. 5	
	International Labor Organization, Indigenous and Tribal Peoples Convention, 1989 (No. 169), Art. 3	

6 – Everyone has the right to healthcare and to the highest attainable level of health.

No one may prevent you or your newborn from getting the healthcare needed or deny or	International Covenant on Economic Social and Cultural Rights, 1966, Article 12	European Convention on Human Rights and Biomedicine, 1997, Article 3

withhold care from either one of you. You and your newborn are entitled to the highest quality care, provided in a timely manner, in a clean and safe environment, by providers who are trained in current best practices.

Convention on the Elimination of all Forms of Discrimination Against Women, 1979, Article 5, 12

Convention on the Rights of the Child, 1990, Article 23, 24

Convention on the Rights of Persons with Disabilities, 2006, Article 25

International Labor Organization, Indigenous and Tribal Peoples Convention, 1989 (No. 169), Art. 25

African Charter on Human and Peoples' Rights, 1998, Article 16

African Charter on the Rights and Welfare of the Child, 1990, Article 14

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, 1988, Article 10

7 – Everyone has the right to liberty, autonomy, self-determination and freedom from arbitrary detention.

No one is allowed to detain you or your newborn in a healthcare facility, even if you cannot pay for services received.

International Covenant on Economic Social and Cultural Rights, 1966, Article 1

International Covenant on Civil and Political Rights, 1966, Article 1, 9.1, 18.1

Convention on the Rights of the Child, 1990, Article 37

African Charter on Human and Peoples' Rights, 1998, Article 6, 20

African Charter on the Rights and Welfare of the Child, 1990, Article 30

American Convention on Human Rights, 1966, Article 7

European Convention on Human Rights, 1950, Article 5

International Labor Organization, Indigenous and Tribal Peoples Convention, 1989 (No. 169), Art. 2, Art. 5

8 – Every child has the right to be with their parents or guardians.

No one is allowed to separate you from your newborn without your consent. You and your newborn have the right to remain together at all times, even if your newborn is born small, premature or with medical conditions that require extra care.

International Convention on Civil and Political Rights, 1966, Article 17

Convention on the Rights of the Child, 1990, Article 9, 16

Convention on the Rights of Persons with Disabilities, 2006, Article 22

American Convention on Human Rights, 1969, Article 11

European Convention on Human Rights, 1950, Article 8

9 – Every child has the right to an identity and nationality from birth.

No one is allowed to deny your newborn birth registration, even if they die shortly after birth, or deny the nationality your newborn is legally entitled to.

International Covenant on Civil and Political Rights, 1966, Article 24

Convention on the Rights of the Child, 1990, Article 7

Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990, Article 2

African Charter on Human and Peoples' Rights, 1998, Article 5

American Convention on Human Rights, 1969, Article 3

10 – Everyone has the right to adequate nutrition and clean water.

No one is allowed to prevent you and your newborn from having adequate nutrition, clean water or a healthy environment. You have the right to information and support on child nutrition and the advantages of breastfeeding.

Convention on the Elimination of all Forms of Discrimination Against Women, 1979, Article 12

Convention on the Elimination of all Forms of Discrimination Against Women, 1979, Article 14(2)

Convention on the Rights of the Child, 1990, Article 24 (2)(c), (2)(e)

International Covenant on Economic, Social and Cultural Rights, Article 11(1)

Convention on the Rights of Persons with Disabilities, 2006 Article 25(1)

African Charter on the Rights and Welfare of the Child, 1990, Article 14(2)

Protocol to the African Charter on Human and Peoples' Rights on the Rights of

Women in Africa, 2005, Article15(a)

Additional Protocol to the American Convention on Human Rights in the Area of

Economic, Social and Cultural Rights, 1999, Article 12(1)

(WRA 2020, own presentation)

Annex 4

ICI Foundational Principles

Advocating rights and access to care

- Women's and children's rights are human rights and must be ensured in all settings and circumstances, including humanitarian and conflict settings. Every woman and newborn, regardless of background, social and educational status, citizenship, age, and health status has the right to access well-staffed and equipped and free or fairly-priced maternal and newborn health services that provide quality care from skilled attendants. Higher rates of maternal and newborn mortality and morbidity resulting from inadequate access to essential care services and poor quality of care are unacceptable.

Ensuring respectful maternity care

- Consideration, respect and compassion for every woman and newborn should be the foundation of all maternity care, even in the event of complications.

- Every MotherBaby should be protected from disrespectful or violent practices of any kind, as well as from infringements on their right to privacy.

Protecting the MotherBaby-Family triad

- The *MotherBaby-Family* refers to an integral unit during pre-conception, pregnancy, birth and infancy influencing the health of one another. Within this triad, the MotherBaby dyad remains recognized as one unit, as the care of one significantly impacts the other. The addition of *Family* to this unit conveys the importance of husbands, partners and the social and/or community family structure in which a child in conceived, born and raised, and emphasizes that maternal care activities and systems need to fulfil the needs of the MotherBaby-Family triad in order to achieve the full potential of safe and respectful maternity care.

- Throughout the entire continuum of maternity care, the MotherBaby-Family should be actively engaged in care provision, aspiring for shared decision making, with the woman ultimately being the decision maker.

Promoting wellness, preventing illness and complications, and ensuring timely emergency referral and care

- Pregnancy, labour, birth and breastfeeding are most often normal and healthy physiologic processes that require supportive care and skilled attention.

- Many pregnancy-related and newborn complications can be prevented or attenuated by primary maternity care and public health measures designed to prevent illness and promote wellness.

- Accessible, appropriate and effective maternal and newborn emergency care is essential for the reduction of maternal and neonatal morbidity and mortality.

Supporting women's autonomy and choices to facilitate a positive birthing experience

- Continuity of supportive care and sensitivity to the mother's cultural, religious, and individual beliefs and values reduce the risk of psychological trauma and enhance women's trust in their caregivers, their experiences of childbearing, and their willingness to accept care and to seek it in the future.

- All women, including those with complications, should receive full, accurate and unbiased information based on best evidence on potential harms and benefits of obstetric and neonatal procedures and alternatives, so that they can make informed decisions about their care and their babies' care. Access to evidence-based prenatal education to prepare women and their partners strongly contributes to this decision making ability.

- Women should have a full range of choices throughout their maternity care experiences, including risk appropriate choices for the place of birth.

- Women with normal, low-risk pregnancies can safely give birth outside of medical facilities in clinics, birth centres, and homes when skilled care and effective referral are available.

Providing a healthy and positive birthing environment: The responsibilities of caregivers and health systems

- Pregnancy, birth, and postpartum practices affect the MotherBaby-Family physiologically and psychologically. A woman's confidence and ability to have a healthy pregnancy and birth and to breastfeed and care for her newborn are

significantly influenced by her birthing environment and can be enhanced or diminished by every caregiver she encounters.

- Establishing a caring and supportive atmosphere, listening to the mother, encouraging her self-expression and ensuring an equal communication interchange in language a woman understands, in order to achieve individualized care, are essential aspects of culturally safe and respectful maternity care.

- Caregivers are individually and collectively responsible to the mother, baby, family, community, and healthcare system for the quality of care provision. The needs of the MotherBaby-Family must take precedence over the needs of caregivers and institutions.

- Healthcare systems are equally responsible for providing safe environments that also take the needs of the providers into account. Skilled providers should be supported to provide optimal care by a sufficient infrastructure that includes adequate supplies, equipment, and staff, without mistreatment or abuse by superiors and with their encouragement and support.

Using an evidence-based approach to maternal health services based on the MotherBaby-Family Model of Care

- Maternal and newborn health benefits from an evidence-based approach to care. Every MotherBaby should be protected from unnecessary and potentially harmful interventions, practices, and procedures and from both overuse and underuse of medical technology.

- The foundation of safe and respectful MotherBaby-Family maternity care is lies in a combination of value-based care models that are driven by health needs and expectations, are based on partnership with women, and contribute to optimizing the normal bio-psycho-social processes of childbirth as well as health outcomes.

- The MotherBaby-Family care model can be practiced by all maternal and newborn health professionals in any setting, in every level of care provision and during obstetrical and neonatal complications and emergencies.

(Lalonde and Pascali-Bonaro 2018, 7-9, own presentation).

Annex 5

The ICI 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care

Explanation	Indicators
1 – Provide Respect, Dignity and Informed Choice	
Treat every woman and newborn with respect and dignity, fully informing and communicating with the woman and her family in decision making about care for herself and her baby in a culturally safe and sensitive manner ensuring her the right to informed consent and refusal. Incorporate a rights-based approach, preventing exclusion and maltreatment of the marginalized and socioeconomically disadvantaged, and including protection of HIV-positive women and women who experience perinatal loss. Under no circumstances is physical, verbal or emotional abuse of women, their newborns and their families ever allowed.	• Feedback mechanisms are provided for addressing complaints (such as a complaint box). • A grievance process is defined and available to mothers and their families. • The charter on Respectful Maternity Care: The Universal Rights of Childbearing Women is displayed. • Local observers witness respectful treatment. • Women's questionnaires and/or interviews show compliance with this Step.
2 – Provide Free or Affordable Care with Cost Transparency	
Respect every woman's right to access and receive non-discriminatory and free or affordable care throughout the continuum of childbearing. Inform families about what charges can be anticipated, if any, and how they might plan to pay for services. Make costs for prenatal education and antenatal, intrapartum and postpartum care visible, transparent and in line	• There are no cases in which women, newborns or infants are refused care or detained after care due to inability to pay.

with national guidelines. Include risk pooling for complications (no additional charge for caesarean delivery or other complications). Forbid under-the-table payments and routinely enforce this rule. Under no circumstances should a woman or baby be refused care or detained after birth for lack of payment.

- Survey and interview responses from women indicate that the fees they were asked to pay meet the advertised rates, and they were not asked/required to provide any extra fees or in-kind payments.

- Informational posters or signs showing all relevant costs in ways comprehensible to families are visibly posted on entrance to the labour and delivery units, and at discharge/cashier. These include information on how patients/families can report non-adherence to the policies and/or requests for bribes.

3 – Routinely Provide MotherBaby-Family Maternity Care

Incorporate value- and partnership-based care grounded in evidence-based practice and driven by health needs and expectations as well as by health outcomes and cost effectiveness. Base care provision on what women want for their newborns and families during the childbirth continuum. Optimize the normal bio-psycho-social processes of childbirth by promoting the midwifery philosophy and scope of practice for most women, within a system that ensures multi-disciplinary collaboration, communication and care for women and newborns, including those with obstetric-neonatal risk and/or complications. Ensure that this MotherBaby-Family care model is available at all levels of care and in any setting and is provided by individual skilled health workers with the full scope of competencies, or within a team with combined competencies.

- Knowledge about this model can be assessed through questionnaires and interviews with providers and management.

- The presence of this care model and its associated practices are observed by accessors.

- Women's questionnaires and interviews indicate that this model is being practiced.

4 – Offer Continuous Support

Inform the mother of the benefits of continuous support during labour and birth, and affirm her right to receive such support from companion(s) of her choice. These include father, partner, family member, doula3, TBA4, or others. Continuous support during labour improves outcomes for women and newborns including: a more positive birthing experience, an increase in spontaneous vaginal birth, a shorter duration of labour, a decrease in the number of caesarean and instrumental vaginal births, less need for analgesics and a low 5-minute Apgar score. Such care appears to be most beneficial when given by a person who is present solely to provide support and is not a member of the woman's own network, is experienced in providing labour support, and has at least a modest amount of training (such as a doula)

- Clear policies stating both verbally and graphically that (birth) companions are welcome into the facility to accompany women in labour are visibly posted and explained in prenatal visits.
- Observers witness that every woman has the option of continuous support.
- Women and families state in interviews and/or questionnaires that accompaniment was encouraged and supported, and that space was made for their chosen companions.

5 – Provide Pain Relief Measures

Offer drug-free comfort and pain relief measures as safe first options, explaining their benefits for facilitating normal birth. Educate women (and their companions) about how to use these methods, including breathing, touch, holding, massage, relaxation techniques, and labouring in water (when available). If pharmacological pain relief options are available and requested, explain their benefits and risks. Train staff in all comfort measures and pain

- Written protocols about comfort measures and pain relief, including the need for increased monitoring of MotherBaby if pharmacological pain relief is used, are in place and made available to assessors.

relief options and to respect women's preferences and informed choices to maximize their confidence and wellbeing.

- In interviews and/or surveys, staff confirm their knowledge of these protocols and report being trained in all methods of comfort measures and pain relief.

- Direct observations can be made as to whether comfort measures and pain relief are being offered and appropriate monitoring is being done.

- Random record review for documenting compliance may be a possibility in some facilities/practices. New mothers can be queried about the availability of pain relief measures via questionnaires and interviews.

6 – Provide Evidence-Based Practice

Provide and promote specific evidence-based practices proven to be beneficial in supporting the normal physiology of labour, birth, and the postpartum and neonatal periods. These include but are not limited to:

Allowing labour to unfold at its own pace, while refraining from interventions based on fixed time limits.

- When possible, refraining from admitting labouring women into labour wards and/ or birthing units until they are in active labour, while ensuring that women in early labour have access to staff and facilities necessary to optimize their wellbeing and that of their baby and

- Posters showing women eating, drinking, walking, and moving about during labour are prominently displayed, as are posters illustrating upright and other physiologic birth positions that include the woman being supported by a companion.

- Tools for facilitating such positions, such as birthing balls, chairs and stools, floor mattresses or pads, and wall ladders and ropes, are clearly visible and easily accessible in labour and birthing spaces.

- Privacy walls or curtains are visible.

- Evidence of staff training in external version and vaginal breech delivery is shown to assessors.

attending family (including supportive care, maternal comfort measures, food and fluids, and space to mobilise and rest).

- Offering the mother access to food and drink as she wishes during labour.

- Supportingthelabouringwomantowalkandmoveaboutfreelyandassisting hertoassume the positions of her choice, including squatting, sitting, and hands-and-knees, and providing tools supportive of upright positions.

- Providing all mothers with privacy during labour and birth, as evidenced by privacy walls or curtains, or separate/individual labour and birthing rooms where possible.

- Training staff to utilize techniques for turning the baby in utero from breech to cephaliclie, and to safely conduct vaginal breech deliveries.

- Facilitating immediate and sustained skin-to-skin MotherBaby contact for warmth, attachment, breastfeeding initiation, and developmental stimulation, and ensuring that MotherBaby stay together.

- Delaying cord clamping to facilitate the transfer of nutrients to the newborn.

- Reliably carrying out all elements considered part of Essential Newborn Care including: ensuring the mother's full access to her ill or premature infant, kangaroo care, and supporting the mother to provide her own milk (or other human milk) to her baby when breastfeeding is not possible.

- Observations by assessors and women's interviews and questionnaires indicate immediate and prolonged skin-to-skin contact, rooming-in, delayed cord clamping, the mother's full access to the neonatal intensive care unit (NICU), and to providing kangaroo (skin-to-skin) care to her newborn.

7 – Avoid Harmful Practices

Avoid potentially harmful procedures that have insufficient evidence of benefit outweighing risk for routine or frequent use in normal pregnancy, labour, birth and the postpartum and neonatal period. When considered for a specific situation, their use should be supported by best available evidence that the benefits are likely to outweigh the potential harms and are consistent with national and/or international guidelines and recommendations, and should be fully discussed with the mother to ensure her informed consent.

- Facility or practice rates of procedures are within acceptable international ranges and are made available to the assessors. Different ranges will be expected for referral practices and referring facilities.
- Benchmarking with other services is available.
- Women's interviews and questionnaires show that they are informed about the reasons for suggested interventions or procedures and their consent is sought.

Routine practices that should be avoided include:

- enema
- sweeping of the membranes
- artificial rupture of membranes
- episiotomy
- frequent or repetitive vaginal exams
- withholding food and water
- keeping the mother in bed or immobilized

- supine or lithotomy position
- numerous caregivers constantly going in and out
- caregiver-directed pushing
- fundal pressure (Kristeller)
- immediate cord clamping
- separation of mother and baby

Practices that can be harmful for low-risk women yet helpful or essential in emergency situations or certain high- risk cases, and thus should only be used when medically indicated, include:

- medical induction or augmentation of labour
- intravenous fluids (IV)

- forceps and vacuum extraction
- manual exploration of the uterus
- suctioning of the newborn

- continuous electronic fetal monitoring
- insertion of a bladder catheter

- caesarean section

8 – Enhance Wellness and Prevent Illness

Promotion of wellness and prevention of illness are the foundations of improving maternal and newborn health. Implement educational and public health measures that enhance wellness and prevent illness and complications for the MotherBaby:

- Provide education about and foster access to good nutrition, clean water, and a clean and safe environment.

- Make water, sanitation and hygiene (WASH) measures part of maternity services. Ensure promotion and provision of clean or boiled water, clean toilet facilities and a clean environment in all birth settings.

- Provideeducationinandaccesstomethodsofdiseasepreventionandtreatme ntformother and baby, including for malaria, syphilis, hepatitis B, toxoplasmosis, HIV/AIDS, and tetanus toxoid immunization.

- Have clear, non-discriminatory policies and guidelines for the treatment and care of HIV- positive women and their newborns. Follow national guidelines on prevention and treatment of HIV in pregnancy, including prevention of transmission and early treatment of HIV-positive newborns.

- Pre- and post-natal education, materials and displays exist that address the criteria described above.

- Staff and providers report being kept up-to-date via ongoing training in these measures for enhancing maternal and newborn wellness and preventing illness, including addressing hygiene and sanitation measures and providing family planning options.

- Women's questionnaires and interviews indicate that the above criteria are included in their care. Observational data confirm that the infrastructure requirements are met to enable the facility or practice to provide these criteria.

- Documentation of family education and preparation for ongoing neonatal care is made available.

- Provide education in responsible sexuality, family planning, and women's reproductive rights, as well as access to family planning options and youth-friendly services.

- Provide supportive and culturally competent prenatal education based on evidence and antepartum, intrapartum, postpartum, and newborn care that addresses the physical and emotional health of the mother and baby within the context of family relationships and community environment, including those women who experience perinatal loss.

- Discharge preparation and planning should include adequate knowledge of postnatal and neonatal care by the mother and family including appropriate immunizations, scheduled follow-up care, understanding of maternal and neonatal danger signs and access to emergency care.

9 – Provide Emergency Care and Transport

Provide access to skilled emergency treatment for life-threatening complications. Ensure that staff are trained in timely recognition of potentially dangerous conditions and complications and in providing effective treatment or stabilization, and have established links for consultation and an accessible and reliable system of transport:

- Ensure birth preparedness and emergency readiness during pregnancy through health promotion activities and organized community and health services mechanisms.

- Emergency treatment drugs, devices and equipment, including magnesium sulphate, uterotonics, balloon tamponade kits, LifeWrap NASGs, resuscitation equipment, oxygen tanks, and transport incubators for sick newborns are visible to observers, as is evidence of ongoing staff training in emergency care and referral.

- Written policies and guidelines for transport and information transfer for referrals are in place.

- Provide planning and arrangements for situations in which the mother or the baby need care beyond the capacity of available resources. Include remote consultation, an effective communication system, and timely and safe transport of the mother and/or infant to a referral facility.
- Ensure that all maternal and newborn healthcare providers have adequate and ongoing training in emergency skills for appropriate and timely stabilization and treatment of mothers and their newborns, including the provision of neonatal and maternal resuscitation.
- Have available drugs, devices and equipment to stabilize and treat mothers and their newborns when complications occur, such as severe hypertensive disorders, severe postpartum haemorrhage, hypovolemic shock, breathing difficulties, and sepsis.

- In the case of referral from home, clinic, birthing centre etc. to a medical facility, women's questionnaires and interviews show that all referrals and those referring are welcomed at the facility and treated with respect and without blame.
- Proof of ongoing education and practice for all emergency procedures is shown to assessors.

10 – Have a Supportive Human Resource Policy

in place for recruitment and retention of all staff, and to ensure that staff are safe, secure, and encouraged and enabled to provide quality care in a respectful and positive work environment. Include an exemption policy that protects the retention and continuity of dedicated, experienced, and skilled maternal healthcare providers (midwives, nurses) in all units and facilities where births take place.

- The policy is available on request and addresses staff safety, security, and exemptions from transfer or rotation policies.
- Surveys or interviews of the staff demonstrate understanding of the policy and can confirm that it addresses the above issues; staff can also provide information on work safety conditions and general work environment issues.

11 – Provide A Care Continuum

Provide a continuum of collaborative maternal and newborn care with all relevant healthcare educators, providers, institutions and organizations. Include traditional birth attendants (TBAs) and others attending at births who have been acknowledged, recognized, and/or integrated into the health services in this continuum of collaboration. Specifically, individuals within institutions, agencies and organizations offering maternity-related services should:

- Collaborate across disciplinary, educational, cultural, and institutional boundaries to provide the MotherBaby with the best possible care within a functioning team, recognizing each other's specific competencies and respecting each other's knowledge and experience.

- FostercontinuityofcareduringlabourandbirthfortheMotherBabyfromas mallnumberof caregivers.

- Have established links with frontline health providers working in primary care and the community to support stabilization, consultations and transfers of care in a timely manner to appropriate institutions and specialists for sick mothers and sick/premature infants.

- Ensurethatthemotherisawareofandcanaccessavailablecommunityservic esspecificto her needs and those of her newborn

- Written policies for collaboration and care transfers are available for inspection.

- Surveys or interviews show that there are established and working mechanisms for periodic communication and fostering good relationships between facility and community health providers.

- Surveys or interviews of outside practitioners demonstrate their knowledge of facility/practice policies and provide descriptions of their experiences working with the facility/practice.

- Staff and women's interviews and questionnaires indicate recognition of collaboration and the presence of continuous care from a small number of providers.

12 – Promote Breastfeeding and Skin-to-Skin Contact

Achieve the 10 Steps of the revised Baby-Friendly Hospital Initiative (2018)—Protecting, promoting and supporting breastfeeding in facilities providing maternity services:

- Comply with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions; have a written infant feeding policy that is routinely communicated to staff and parents; establish ongoing monitoring and data-management systems.
- Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.
- Discuss the importance of management of breastfeeding with pregnant women and their families.
- Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
- Support mothers to initiate and maintain breastfeeding and manage common difficulties.
- Do not provide breastfed newborns with any food or fluids other than breast milk, unless medically indicated.
- Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.

- Staff can be observed encouraging skin-to-skin contact and mothers kept together with their newborns, establishing breastfeeding as soon as possible.
- The facility provides combined care and sufficient space for the MotherBaby in beds large enough for both with bassinets at hand (when available).
- No pharmaceutical posters advertising infant formula are displayed and no infant formula is provided as a parting gift.
- Culturally appropriate and heavily graphic posters in local languages depicting skin-to-skin contact and breastfeeding, along with explanations of their benefits, are prominently placed.
- Women's questionnaires and interviews indicate the facility's or practice's compliance with these revised BFHI 10 Steps.

- Support mothers to recognize and respond to their infants'cues for feeding.
- Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
- Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

(Lalonde and Pascali-Bonaro 2018, 11-18, own presentation).

Annex 6

Lists of feelings and needs by the Center for Nonviolent Communication

FEELINGS – WHEN THE NEEDS ARE SATISFIED

AFFECTIONATE	compassionate friendly, loving, open hearted sympathetic, tender, warm
ENGAGED	absorbed, alert, curious, engrossed, enchanted, entranced, fascinated, interested, intrigued, involved, spellbound, stimulated
HOPEFUL	expectant, encouraged, optimistic
CONFIDENT	empowered, open, proud, safe, secure
EXCITED	amazed, animated, ardent, aroused, astonished, dazzled, eager, energetic, enthusiastic, giddy, invigorated, lively, passionate, surprised, vibrant
GRATEFUL	appreciative, moved, thankful, touched
INSPIRED	amazed, awed, wonder
JOYFUL	amused, delighted, glad, happy, jubilant, pleased, tickled
EXHILARATED	blissful, ecstatic, elated, enthralled, exuberant, radiant, rapturous, thrilled
PEACEFUL	calm, clear, headed, comfortable, centered, content, equanimous, fulfilled, mellow, quiet, relaxed, relieved, satisfied, serene, still, tranquil, trusting
REFRESHED	enlivened, rejuvenated, renewed, rested, restored, revived

FEELINGS – WHEN THE NEEDS ARE NOT SATISFIED

AFRAID	apprehensive, dread, foreboding, frightened, mistrustful, panicked, petrified, scared, suspicious, terrified, wary, worried
ANNOYED	aggravated, dismayed, disgruntled, displeased, exasperated, frustrated, impatient, irritated, irked
ANGRY	enraged, furious, incensed, indignant, irate, livid, outraged, resentful
AVERSION	animosity, appalled, contempt, disgusted, dislike, hate, horrified, hostile, repulsed
CONFUSED	ambivalent, baffled, bewildered, dazed, hesitant, lost, mystified, perplexed, puzzled, torn
DISCONNECTED	alienated, aloof, apathetic, bored, cold, detached, distant, distracted, indifferent, numb, removed, uninterested, withdrawn

DISQUIET	agitated, alarmed, discombobulated, disconcerted, disturbed, perturbed, rattled, restless, shocked, startled, surprised, troubled, turbulent, turmoil, uncomfortable, uneasy, unnerved, unsettled, upset
EMBARRASSED	ashamed, chagrined, flustered, guilty, mortified, self-conscious
FATIGUE	beat, burnt out, depleted, exhausted, lethargic, listless, sleepy, tired, weary, worn out
PAIN	agony, anguished, bereaved, devastated, grief, heartbroken, hurt, lonely, miserable, regretful, remorseful
SAD	depressed, dejected, despair, despondent, disappointed, discouraged, disheartened, forlorn, gloomy, heavy, hearted, hopeless, melancholy, unhappy, wretched
TENSE	anxious, cranky, distressed, distraught, edgy, fidgety, frazzled, irritable, jittery, nervous, overwhelmed, restless, stressed out
VULNERABLE	fragile, guarded, helpless, insecure, leery, reserved, sensitive, shaky
YEARNING	envious, jealous, longing, nostalgic, pining, wistful

NEEDS

CONNECTION	acceptance, affection, appreciation, belonging, cooperation, communication, closeness, community, companionship, compassion, consideration, consistency, empathy, inclusion, intimacy, love, mutuality, nurturing, respect/self-respect, safety, security, stability, support, to know and be known, to see and be seen, to understand and be understood, trust, warmth
PHYSICAL WELL-BEING	air, food, movement/exercise, rest/sleep, sexual expression, safety, shelter, touch, water
HONESTY	authenticity, integrity, presence
PLAY	joy, humor
PEACE	beauty, communion, ease, equality, harmony, inspiration, order
AUTONOMY	choice, freedom, independence, space, spontaneity

MEANING	awareness, celebration of life, challenge, clarity, competence, consciousness, contribution, creativity, discovery, efficacy, effectiveness, growth, hope, learning, mourning, participation, purpose, self- expression, stimulation, to matter, understanding

(CNVC 2005, own presentation)